Maternal and Child Health Services
Title V Block Grant

State Narrative for New York

Application for 2009
Annual Report for 2007

Document Generation Date: Monday, September 22, 2008

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and Certifications will be kept on file in the office of the Title V Director, New York State Department of Health, Division of Family Health, Corning Tower Room 890, Empire State Plaza, Albany NY 12237-0567. In addition, assurances and certifications are reprinted in hardcopy and web-based versions of the block grant application. Hardcopies are available at the above address. The grant application appears on the New York State Department of Health Website at: www.health.state.ny.us.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

The New York State Department of Health, as New York's Title V agency, has several methods for making this application public and for soliciting, accepting and incorporating public input during its development and after its transmittal. These include:
-using a variety of public interactions /2008/, including outreach to specific stakeholders and populations, to introduce the grant and make known the various ways in which the public can be involved;//2008//
-placing the document on our public website and making hardcopies available through the Division of Family Health;
-an active and involved Advisory Council, statutorily-established as a method of public input;
-public hearings, rotating locations across the State /2008/ (in 2007, hearings were held in Syracuse and NYC.)//2008//
-surveying parents of Children with Special Health Care needs for parent involvement and other relevant issues /2008/, including New York's Family Champions;
-working with a Youth Advisory Committee; //2008
-conducting focus groups with Title V consumers and Title V-eligible groups across the State;
-soliciting advice from the Healthy Start-Title V Collaboration Consumer Group;
-meeting annually with LEND scholars and others providing services to Children with Special Health Care Needs; and
-accepting phone calls, letters, faxes and e-mails regarding the content of the document and the needs of the population. See Section II.

The Needs Assessment document has been updated to include information on what public input was obtained. Results of all public input processes are shared with program staff and agency administration for incorporation into program planning, policies and procedures.

Each year, New York updates the Glossary in order to facilitate public understanding of the Block

Grant process. State-specific abbreviations and information are added to the Federal boilerplate in order to make the block grant application more understandable and readable to its multiple audiences.

In 2006 in preparation for the FFY 2007 application, public hearings were held in New York City, Buffalo and Albany. Topics brought to the hearing included continued support for the NYS Center for Sudden Infant Death and their services; childhood nutrition; and oral health. /2008/In 2007, public hearings were scheduled for Syracuse and New York City.//2008//

Focus groups were also held in various parts of the state with differing target populations. New York has been conducting focus groups on maternal and child health issues since 1999. The purpose of conducting focus groups is to gather information directly from consumers about health issues and what most concerns them. New York considers these focus groups to be a very useful addition to other forms of public input. Confidentiality is of the utmost importance. Participants received travel reimbursement, culturally-appropriate nutritious snacks and stipends for their participation. Child care is also provided.

An attachment is included in this section.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2009/ Summary:

New York continues to submit annual updates to its needs assessment not only as a service to the many organizations and individuals who rely on these data for their own planning needs, but also to ensure that the data is collated at least annually to allow course corrections as needed to the many Divisions, Bureaus, Units and Programs within the Department of Health.

Changes to the Needs Assessment include incorporation of NYC PRAMS data, which is presented in contrast to the PRAMS data for the rest of the state, since a combined dataset is not yet available. CDC representatives are working on developing the first-ever statewide sample, which is expected to be ready for reporting in the next MCHSBG application. State Performance Measures are unchanged. All data were updated to reflect the most recent year of data available.

The Needs Assessment provides a description of the needs assessment process, how it relates to priority setting, and how these result in funding decisions. This is not to say, however, that the process is simple or easy to understand. New York State has such a wealth of federal, state, and local programs and resources available to our residents, and an equally if not greater abundance of pockets of need, populations at risk for various conditions, gaps in services, etc., that there is no simple way to describe the multifaceted approach that is taken to priority setting. Nevertheless, this rather lengthy needs assessment section attempts to describe this process, using the most recent data available for decision-making purposes. We have also attempted to make clear that our methods for monitoring ensure that programs are accountable for activities and outcomes, and that this is an iterative process that shapes programs on an ongoing basis to take new methods into account and modify activities that do not meet outcome expectations.

A further purpose served by this needs assessment is that it provides an opportunity for New York State to provide a narrative overview of programs and initiatives in this state that comprise our maternal and child health services. While the outcome and performance objectives in the narrative provide specifics regarding particular topic areas, this approach does not permit an overall picture of our services, as described in the needs assessment.//2009//

As a result of New York Title V needs assessment process, the following ten priorities have been identified:

1. To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care, which includes attention to mental health issues and which serves those with special health care needs;
2. To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
3. To prevent and reduce the incidence of overweight for infants, children and adolescents;
4. To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;

5. To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
6. To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
7. To reduce unintended and adolescent pregnancies;
8. To ensure the availability of comprehensive genetics services statewide, including follow-up on positive newborn screening results, specialty services and genetics counseling for affected families;
9. To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicides in 15- to 19-year-olds; and
10. To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

The justification for their selection as priorities may be found in Section II. B.1. and a description of our planning/targeting framework may be found in Section II.A.

Priority setting was conducted as a melding process, combining:

- The results community-participative processes;

- The use of the many and various data sets available to the Department, such as:
- Routine surveillance of vital statistics/vital records;
- Census data;
- Registries;
- Hospital discharge data;
- Special studies;
- Community-based assessment data;

- The use of program data and provider input to identify trends and issues;

- Infrastructure evaluation;

- The input of the public and the Maternal and Child Health Services Advisory Council, including the input of those who spoke at focus groups, the public hearings or sent testimony, to assist in interpreting data and identifying important trends, gaps in services or barriers to care; and

- The input of key staff within the Department.

The basic process remains unchanged since the last application. Collaborations and partnerships that contribute to the needs assessment process have also remained unchanged. NYSDOH will continue to strive to meet these needs.

The full updated Needs Assessment is provided as an attachment to this section.

III. State Overview
A. Overview
A. Overview

/2009/ Summary: In early 2008, as will be addressed more fully in the 2008 report, the Lieutenant Governor, David Paterson, assumed the role of Governor in New York State. The Governor has a strong commitment to improving public health. The Commissioner of Health in New York State, as his representative, has made significant inroads in implementing public health initiatives designed to further improve the health of New Yorkers. These initiatives include extending accessibility and streamlining processes for obtaining insurance benefits, further enhancing our focus on prevention efforts, increasing the effectiveness of surveillance efforts and emergency preparedness, and improving and sustaining access to high quality, continuous primary health care for all New Yorkers. These priorities will all be addressed in a manner cognizant of the diversity of our population, including differences in socioeconomic status, and the need to especially ensure that services for pregnant women, infants, and children are accessible and effective. A re-design of the state's Medicaid payment system to better reimburse provision of comprehensive services to vulnerable populations is anticipated in the coming year.//2009//

/2008/In 2007, New York has both a new Governor and a new Health Commissioner. As a result, New York is now placing a new emphasis on extending health insurance and putting patients first. Here are some of the Commissioner's overall goals for the Department:

- Working with the Governor, the Legislature and other constituencies, the Department of Health will help design a plan whereby every New Yorker has access to affordable health insurance. In ***/2009/ former //2009//***Governor Spitzer's State of the State address ***/2009/ in 2007 //2009//***, he pledged to reform New York's health care system to make health care affordable for every person, family and business, as well as for government.
- To improve the health status of all New Yorkers, the Department will promote a "culture of wellness" in New York State where prevention and healthy lifestyles are taught, valued and exercised.
- To prevent serious health problems and improve outcomes, the Department will seek reforms in the health care system that result in greater use of prevention, health education and primary care.
- The Department will strengthen statewide and community-based efforts to reduce the most preventable causes of illness and disability, including tobacco use, obesity, asthma, diabetes, HIV/AIDS, heart disease, and certain preventable types of cancer.
- To protect New Yorkers from environmental health risks, the Department will strengthen efforts in environmental health education, prevention, surveillance and response.
- To improve the quality of life for New York's seniors and disabled, the Department will seek to expand options that allow these individuals to obtain needed medical care and assistance with daily living while remaining in their homes and other least-restrictive community settings.
- To improve quality and effectiveness in the health care system, the Department will expand the use of health information technology and evidence-based strategies that achieve the best outcomes while preventing medical errors.
- Recognizing that minorities and other low-income New Yorkers continue to experience lower health status than others, the Department will develop and implement more effective health care provider and community-based strategies to eliminate these health disparities.
- To provide the greatest protection possible to New Yorkers in the event of a public health emergency, the Department will improve disease surveillance and reporting, educate New Yorkers on prevention, and strengthen planning and preparedness with the Department's federal, state and local partners.
- To ensure a strong scientific foundation for the Department's public health efforts and to enhance efforts to detect, prevent and treat serious public health conditions, the Wadsworth

Center will strengthen research, testing and quality assurance activities.

- To increase the effectiveness of local public health efforts across New York State, the Department will strengthen collaboration with, and support for, local public health departments.
- To ensure the availability of a strong public health workforce, the Department in conjunction with the School for Public Health will strengthen efforts to promote careers in public health and provide cutting-edge public health education and training.

Commissioner Daines is in the process of developing additional public health goals for the Department as he meets with employees and the public over the coming months. He is encouraging all staff to identify all barriers to achieving our goals and to break them down.//2008//
/2008/On January 26th, 2007, ***/2009/ former //2009//*** Governor Spitzer outlined his agenda for fundamental reform and restructuring of the health care system, decreasing costs while increasing coverage. These reforms will save taxpayers billions of dollars while still improving patient outcomes. This agenda is called Patients First. This new agenda calls for greater scrutiny of where health care dollars are being expended and holding institutions to greater accountability for health care dollars. Monies will be shifted away from institutions-centered health care system to an effective patient-centered system for the future. Cornerstones of this plan include:

- Providing access to health insurance to all 400,000 uninsured children. To do this, New York will extend Child Health Plus to cover children in families up to 400% of the federal poverty level, so that every family in New York will be able to provide their children with the health insurance coverage that they need.
- Removing bureaucratic barriers that prevent people from getting on and staying on Medicaid. While implementing safeguards against fraud, we will no longer require families to produce documents for continued eligibility. Our own data will be used to confirm continued eligibility.

The goal of these two measures is to cut the uninsured population in half over the next four years and to save the state millions of dollars by reducing charity care in emergency rooms.
The Patients First agenda also includes a plan to develop an affordable, universal health insurance system for all New Yorkers. This cannot be achieved unless our health care delivery system is restructured to lower health care costs to ensure that it is not an undue burden on families, businesses and government to cover the cost of universal coverage.
The plan is that as New York expands coverage, there will be reforms in the Medicaid delivery system. Medicaid rates paid to nursing homes and hospitals are to be frozen, with a partial freeze on Medicaid managed care. Reform efforts include:

- Ensuring that the Graduate Medical Education (GME) system provides the state with the value desired for the funds invested;
- No longer using Medicaid to cross-subsidize commercial insurers, nor supporting deep discounts for hospital services their members use.
- Paying fair reimbursements that reflect the true costs of providing high-quality care through a workforce whose needs are met fairly, redirecting Medicaid dollars to those facilities that serve the bulk of the Medicaid patients.
- Strengthening the state's Preferred Drug List, increasing the use of clinical equivalents and promoting best practices. New York is looking into bulk purchasing and the federal 340B drug discount program.
- Purchasing health care in the appropriate setting, using the highest standards at the best price, and starting with the patients that have multiple medical needs. With better coordination of care, patients with medically-complicated conditions will get better care, their conditions will be better managed, and the cost of their total care will be reduced.
- Expanding the managed long-term care programs which have been successful in coordinating and managing long-term care needs.
- Driving the implementation of health information technology, which is essential to improving health care quality, reducing bureaucratic barriers and saving health care dollars.
- Increasing efforts to root out Medicaid fraud, which wastes precious resources and reduces our ability to care for those in need. Governor Spitzer is proposing to the New York State legislature a Martin Act of Medicaid and a State False Claims Act. This legislation saved

the federal government billions since its implementation.

- Targeting primary and preventive public health strategies that will decrease obesity rates, increase healthy eating and physical exercise, prevent childhood lead poisoning, expand access to cervical cancer vaccines, prenatal and postpartum home visiting, high-quality mammograms and public health education.

The Governor has called for collaboration and partnership in making the Patients First agenda a reality. It is his intention that partners will include individuals, businesses, health care workers and the health care industry. He has called for all to come together as One New York. //2008// /2008/In addition to these goals for health in New York, ***/2009/ former //2009//*** Governor Spitzer and ***/2009/ former //2009//*** Lieutenant Governor ***/2009/, and current Governor //2009//*** David Paterson have announced a comprehensive strategy to ensure that all of New York's children are given an equal opportunity to achieve success. The Children's Agenda is a plan for a series of actions that will provide the groundwork for healthy and successful lives. Governor Spitzer explains that the children's agenda will "focus our state's resources and energy on the particularly vulnerable period in a child's life when development is most important." ***/2009/ Former //2009//***Lieutenant Governor ***/2009/, now Governor,//2009//*** Paterson, goes on to state, "All of our children deserve a level playing field. From the prevention and treatment of childhood obesity to protecting them from violent video games, this initiative ensures that we have the tools in place for them to succeed in New York."

The Children's Agenda will:

- Through Executive Order, establish a Children's Cabinet that will bring together the multiple state agencies to implement the reforms that will be required for the success of New York's children. The cabinet will consist of the diverse agency commissioners, chaired by the Director of State Operations Olivia Golden, and co-chaired by the Deputy Secretary for Health and Human Services Dennis Whalen and Deputy Secretary for Education Manny Rivera.
- Charge the Children's Cabinet with the implementation of budget priorities to support the positive development of children and universal pre-Kindergarten.
- Introduce legislation including a Healthy Schools Act to strengthen school nutrition and junk-food standards, a Safe Games Act to create of mechanism whereby retailers cannot sell sexually-explicit and excessively-violent video content to children, and Anti-Tobacco legislation that will prohibit the sale of flavored cigarettes because of their dangerous ability to hook kids on smoking. //2008//

As previously described, New York has undergone extensive priority-setting processes. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

The following are New York's maternal and child health services priority needs:

- To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and which includes attention to mental health issues and which serves those with special health care needs;
- To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
- To prevent and reduce the incidence of overweight for infants, children and adolescents;
- To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
- To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
- To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
- To reduce unintended and adolescent pregnancies;
- To ensure the availability of comprehensive genetics services statewide, including follow-up on positive newborn screening tests, specialty services and genetics counseling for affected families ***/2009/ and for individuals and families at risk for genetic disease//2009//***;
- To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicides in 15- to 19-year-olds; and
- To improve parent and consumer participation in the Children with Special Health Care

Needs Program, as evidenced by parent scores.

Improving and sustaining access to high-quality, continuous primary health care and treatment services are critical to improving health outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The hallmarks of success will be prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" and a "dental home" for every New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive health services to people in need, and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicine. Title V works closely with the /2008/new Office of Health Insurance Programs//2008// to ensure continuity and coordination with public insurance programs and to ensure that any gaps in care are recognized and acted upon.

Please see Section II. Needs Assessment for a more complete description of New York State's geography, population, resources and health care delivery environment.

Measuring success will rely on accurate assessment of progress. Factors that play a role are:

Diversity: Recapping the Needs Assessment, New York's diverse geography can also present interesting public health challenges. The state has both urban centers and sparsely populated rural areas. New York's beautiful natural resources attract tourists year-round to our historic and recreational attractions, which can produce variable seasonal demand on health services, especially in the areas of emergency medical services and public health. Seasonal variations in weather also affect how and when New Yorkers seek services. Heavy "lake effect" snowstorms can delay access to care and make travel dangerous, especially in the northern and eastern areas of the State.

Our population is even more diverse than our geography, more diverse than the nation as a whole, with New York City being the most diverse area. On the 2000 Census, 67.9% of New York residents reported they were White alone, 15.9% reported they are Black or African American alone, 5.5% reported that they were Asian alone, 0.4% reported they were American Indian or Alaskan Native, and 7.1% reported being some other race. 15.1% of the State's total respondents reported that they were Hispanic. Over 3.1% of New Yorkers identified themselves as being of more than one race. Native Americans were severely undercounted.

New York is also home to many new New Yorkers and new Americans. New York ranks higher than the country as a whole for non-Hispanic Black residents, Hispanic residents, and non-citizen residents. We are second among states for non-citizen immigrants. /2008/According to the American Community Survey conducted by the US Census Bureau, New York ranks second of all states in foreign born, with 21.4% (±0.2%) of its total population or ~4,120,500 people being foreign born in 2005.//2008// ***/2009/ In 2006, 21.6% of the state's total population, or 4,178,962, were estimated as being foreign born, as slight increase over 2005.//2009//*** Almost 90% of New York's non-citizen immigrants live in New York City. Of the estimated 17,144,924 New Yorkers over age 5, an estimated 12,440,299 speak only English at home, while 4,704,625 speak a language other than English. 2,092,875 speak English less than "very well." About 2,360,792 New Yorkers speak Spanish at home. ***/2009/ According to the 2006 American Community Survey, these numbers increased in 2006. With an estimated 18,085,173 New Yorkers over age 5, it was estimated that 12,875,365 speak only English at home, while 5,209,808 speak a language other than English. Of those speaking a language other than English at home, 2,372,334 speak English less than "very well." About 2,574,121 New Yorkers speak Spanish at home.//2009//***
Poverty and Health Care: Poverty is major factor for affordability and access to health care services. /2008/In 2005, 14.5 percent of the population lived below the federal poverty level (FPL). This is higher than the national average of 12.6 percent. About 18.6 percent of New Yorkers had incomes below 125% of poverty. According to the 2005 American Community survey, in New York State, 26 percent of persons with less than a high school education live

below poverty. Among females without a high school education the percent below poverty is 31 percent. In New York State, 19.1% of women giving birth in 2005 had less than a high school education. Among African American and Hispanic women, the percentage is even higher (24.0% and 40.2%, respectively). According to the 2006 Current Population Survey, during 2005, 43.6 percent of the people in female-headed households with children lived below poverty in New York State.//2008//

/2008/ Lack of Insurance: About 7.7 percent of children between birth and 17 years of age were uninsured in NYS in 2005. According to the New York State Behavioral Risk Surveillance Survey, 10.6% of those surveyed in 2006 did not see a doctor when they needed to because of cost.//2008// To address the health care needs of the uninsured, New York has a comprehensive Medicaid package, Child Health Plus, Family Health Plus and Healthy New York.

Pregnancy and Birth Rates: /2008/ In 2005, there were 3,474 fewer births than occurred in 2004. Adolescent birth and pregnancy rates continued declining and are below national averages. ***/2009/There were 249,206 births in New York State in 2006. Of these, 119,430 were to residents of NYC and the remaining 129,776 were to Upstate NY residents. This is 3,804 more births than occurred in 2005. The numbers of births increased in both New York City and Upstate New York.//2009//*** /2008/Birth rates among Black and Hispanic teens were significantly higher than among White teens. During 2005, there were 34.4 births for every 1,000 Hispanic teen girls aged 15-17 in New York State. This is more than 3 times the rate for White teens (11.1 per 1,000) in this age group. Among Black 15-17 year olds the birth rate, at 22.2 per 1,000, was exactly double the rate for white teens.//2008// ***/2009/ These rates were essentially unchanged in 2006.//2009//*** The rate of unintended pregnancy among PRAMS respondents /2008/ declined slightly to 32.7%//2008 during this same time period. Those most at risk for unintended pregnancy were /2008/ women under the age of 20 (63.4%); women who were not married (54.5%); African American women (55.7); women on Medicaid (48.1%); and women with less than a high school education (48.9%).//2008// ***/2009/ In 2006, about one third of new mothers responding to the PRAMS survey indicated that their pregnancy was unwanted or mistimed (33.4%), which was slightly higher than the 2005 rate.//2009//***

Prenatal Care: The percentage of women entering prenatal care in the first trimester /2008/ continued to show//2008// improvement. /2008/ In 2005, the rate was 75.4%.//2008// ***/2009/ The rate fell slightly in 2006, to 74.6%.//2009//*** During that same time period, adequacy and content of prenatal care improved among all regions and among all racial and ethnic groups. ***/2009/ In 2006, however, there was a slight decrease in adequacy of prenatal care in NYS outside of NYC, from 73.2 to 71.8 percent.//2009//***

Other positive trends in the PRAMS data were noted:

- Fewer mothers reported drinking alcohol while pregnant.
- Fewer mothers reported smoking prior to, during, and after pregnancy.
- Fewer mothers exposed their babies to second-hand smoke.
- Fewer mothers experienced physical abuse during pregnancy.
- More mothers initiated breastfeeding.
- /2008/ Fewer mothers reported that their pregnancy was unwanted or mistimed.//2008/
- More mothers had knowledge of the positive effects of folic acid on birth defects.

/2009/ The 2006 PRAMS data indicated a slight rise in the percentage of mothers reporting drinking during the last 3 months of pregnancy, 7.6% vs. 7.0% in 2005, but in general, positive trends in behaviors reported by pregnant women continued.//2009//

/2009/In 2006, 95.7% of women presenting for delivery in New York State had received counseling and testing during pregnancy.//2009// Prenatal care enrollment increased among HIV+ women and more women presenting for delivery had received counseling and testing during pregnancy. The percent of HIV-exposed infants who received prenatal, intrapartal or neonatal ARV to reduce transmission also increased. /2008/ Despite these efforts the number of HIV infected infants rose slightly in 2005 to 13 (up from 8 in 2004.).//2008// ***/2009/ In 2006, this number decreased to 10 (1.7% of the exposed infants) infants infected by mother-to-child***

transmission.//2009//

/2009/ In 2007, the New York State Department of Health widely distributed a "Health Alert: Steps to Further Reduce Mother-to-Child HIV Transmission in New York State" to all NYS birth facilities as well as to over 13,000 NYS physicians including obstetricians/ gynecologists and family practitioners. The Health Alert was also distributed to midwives, HIV specialists and designated AIDS Centers. The "Health Alert" contained recommendations for repeat HIV testing in the third trimester, identifying acute HIV infection during pregnancy, a one-hour turnaround time for rapid HIV test results in delivery settings, and assuring access to care and supportive services for HIV-positive pregnant and postpartum women.//2009//

Low and Very Low Birth Weight: Overall rates of low birth weight and very low birth weight have been relatively unchanged over ten or more years. The rate for singleton births has declined, indicating that the increase in multiple births seems to be responsible for the unchanged overall rates. Though disparities in low birth weight rates have shown some improvement over time, they still persist.

/2008/Preterm Births: The preterm birth rate in New York State increased 8% over the two years from 2003 until 2005. Rates in both New York City and the Rest of State have increased since 2003. ***/2009/ These rates continued to rise in 2006, reaching 12.5% for the state as a whole, an increase of 9.6% since 2003.//2009//*** The preterm birth rate in New York City has been consistently higher than rates in Rest of State during the past 10 years. The percentage of Black women delivering at less than 37 weeks gestation was higher than among White women. Hispanic women giving birth had a premature rate 17% higher than the rate among White women but 20% lower than the rate for Black women. These disparities between Black, White and Hispanic births have persisted over the past ten years. //2008// ***/2009/ Racial disparities decreased somewhat in 2006, with the rate among Hispanic women only 9.4% above the rate for whites, and 19.1% below the rate for black women.//2009//***

Maternal Mortality: Wide fluctuations in rates appear to be a result of the rarity of the occurrence and the zealousness of ascertainment. Rates are highest in New York City and among African American women. /2008/The overall rate of declined markedly from 2004 to 2005, from 20.5 per 100,000 in 2004 to 14.7 per 100,000.), which is about 4.5 times the Healthy People 2010 goal of 3.3 per 100,000. Racial and ethnic disparities persist. The 2005 Black maternal mortality rate was 38.8 (20 deaths), the Hispanic rate was 8.7 (5 deaths) and the White rate was 8.2 (13 deaths). The Black-to-White ratio was 4.7. //2008// ***/2009/ The rate again increased in 2006, to 19.3 deaths per 100,000 births, but this may have resulted from Department of Health efforts to address the rate in conjunction with the American College of Obstetricians and Gynecologists, through our Safe Motherhood project. Correct ascertainment and reporting of maternal deaths is a key component of this initiative.//2009//***

Children: There were some very encouraging and some not-so-encouraging trends. /2008/

- In 2005, the percent of two- to four-year-olds participating in New York's WIC Program that were overweight was down 5% from 2004, but still a 28% increase since 1989. The percent of overweight children varies considerably by race and ethnicity. Hispanic children are almost twice as likely to be obese than Black or White children. ***/2009/ In 2006, 15.2% of the two- to four-year-olds participating in New York's WIC Program were overweight. This is down 9% from the 2003 high of 16.8%, but still a 16% increase since 1990. //2009//***
- Breastfeeding initiation rates and breastfeeding at one month of age among PRAMS respondents increased. Rates are also up among the WIC population and among respondents to the National Immunization Survey.
- Data from the 2005 YRBS found that 10.5% of adolescents are overweight (BMI = 95%). Adolescent males were more likely to be overweight than females and African American adolescents were more likely to be overweight than white adolescents. Among Hispanic males

almost 20% were overweight in 2005. ***/2009/ The 2007 YRBS found 10.9% of adolescents were overweight, a slight increase over 2005 levels.//2009//***

- On a NYSDOH third grade survey 54.1% had experienced dental caries. 33.1% had untreated caries, well above the Healthy People 2010 target of 42% and 20%, respectively. Consistently, both caries experience and untreated caries were more prevalent in the low-income group.
- From 1995 to 2005, childhood asthma hospitalization rates declined 36% to 58 per 10,000. ***/2009/ During 2006, there was a small increase in the rate to 60.1 per 10,000. //2009//*** Otitis media hospitalizations declined dramatically in the same time period.
- 98.8% of infants born in the state were tested for hearing before discharge from the hospital.
- New York has surpassed the HP 2010 goal for immunization levels in two-year-olds. Vaccine-preventable disease rates are down.
- Rates of gonorrhea have declined among teens, but rates for early syphilis increased slightly among NYC teen females. Chlamydia rates declined among males and females, but less dramatically among females. ***/2009/ Chlamydia rates for male teens increased significantly in 2006, possibly because of increased emphasis on Chlamydia testing for sexually active teens.//2009//***
- With regard to risk-taking behavior, the 2005 YRBS showed seat belt and bike helmet use increasing, fewer students using violence, and fewer students feeling sad or hopeless everyday. New York has a lower percentage of sexually active teens than the country as a whole. More New York teens reported using condoms at last intercourse than teens in the rest of the country. However, more children reported being afraid for their safety at school.
- Infant mortality rates are declining. //2008//

Health Insurance: New York's public insurance programs include the Medicaid program, Child Health Plus and Family Health Plus. There are additional health insurance programs that assist small businesses and people who have lost health insurance with access to insurance products. Data from the National Survey of American Families shows New York to do better than the US average for insuring the poor (13.5% uninsured vs. 15.9% in the US, according to adjusted Census figures).

Health Care Access: Health care access is most difficult for the uninsured, those with less education and those whose primary language is not English. Other barriers to access include high out-of pocket-expenses, lack of public transportation and a maldistribution of health care professionals, especially dentist and specialists that are willing to accept Medicaid as payment.

B. Agency Capacity

/2009/ Summary: //2009// The New York State Department of Health, as the Title V agency in New York State, plays a major role in assuring quality and access to essential maternal and child health services. Title V, the Maternal and Child Health Services Block Grant, provides the basic framework for provision of all maternal and child health services by the New York State Department of Health. ***/2009/ This section of the application describes the roles and responsibilities of the Department of Health, the types of monitoring methods utilized to ensure that problems are quickly identified and addressed, and the methods used to ensure that new health hazards are quickly identified and appropriate interventions deployed. This section also reflects our approach to ensuring health by describing how we work to educate the community, since an educated consumer is one who assumes a strong role in his/her own health, and how we mobilize community organizations and others to partner with us in implementing health initiatives. This section also describes the array of statutory and regulatory tools available to the state to inform providers and consumers of current standards of care, and compel compliance as needed to ensure the health of our citizens. Another role described in this section is how the state promotes linking of women, infants and children to high quality health and human services -- a***

multifaceted effort to ensure not only access to services, especially for women and children who face special challenges, but to improve the quality of services on an ongoing basis. This effort presupposes that monitoring of the quality, availability, accessibility (financial, linguistic, and cultural), and quality of services is conducted on an ongoing basis. The full scope of this massive state effort is difficult to adequately convey, since the process for funding services, which are largely conducted by external contractors, involves an extensive system of checks and balances to ensure that appropriate services are delivered to the most needy segments of the population, that funds are used exclusively for specified purposes, that only contractors fully informed about the needs of their target population and capable of providing high quality services receive funding, that monitoring and reporting on progress are an integral part of the process, and that an ongoing, iterative process of program re-design is undertaken to ensure that modifications of activities, target populations, types of services delivered, etc., occur as needed to best improve the health and well being of our citizens. Part of this process is implementation of research and demonstrations to gain insights and develop innovative solutions for maternal and child health populations, and ensuring that a properly trained public health work force is maintained. Recognizing the role of cultural competency in service delivery settings, a separate subsection has been added to provide a macro view of Department efforts to improve the cultural competency of our staff and our providers statewide.//2009//

Please see a full description of agency capacity as it appears in the Needs Assessment.

Title V Roles and Responsibilities: The Title V role of the New York State Department of Health includes:

- assessing and monitoring maternal and child health status to identify and address /2008/problems and disparities in health outcomes;//2008
- diagnosing and investigating health problems and health hazards affecting women, infants, children and youth in New York State;
- informing and educating the public and families in New York State about maternal and child health issues (and we encourage the public to educate and inform us, as well);
- mobilizing partnerships between policy makers, providers, families and the public to identify and solve maternal and child health issues in New York State, /2008/ especially to address disparities in health outcomes;//2008//
- providing leadership in priority-setting, planning and policy development to support county and community efforts to assure the health of women, infants, children, youth and their families;
- promoting and enforcing legal requirements that protect the health and safety of women, infants, children and youth in New York State and to ensure public accountability for their well being;
- linking women, their infants, children and youth to health and other human services and to assure access to comprehensive, high quality systems of care /2008/ and health equity//2008//;
- assuring the capacity and competency of the public health/maternal and child health workforce to effectively address maternal and child health needs within the State;
- evaluating the effectiveness, accessibility and quality of personal health and population-based maternal and child health services; and
- supporting research and demonstrations to gain insights and innovative solutions to maternal and child health-related problems.

Assessing and monitoring maternal and child health status to identify and address problems: Please refer to the Needs Assessment portion of this document, which reflects our structures and capacity to gather, analyze and report data across a variety of areas, populations and providers.

NYSDOH is able to track problems and hazards specific to the maternal and child health population, including but not limited to:

- vital events (births, deaths, fetal losses, causes of death);
- vaccine-preventable and other diseases and conditions affecting the maternal and child health population (STDs, lead poisoning, dental caries, unintended pregnancies, injuries);
- perinatal conditions of the newborn and mother (low birth weight, very low birth weight)
- ***/2009/ care delivered to newborns in neonatal intensive care units statewide, via the NICU module of the Statewide Perinatal Data System; //2009//***
- /2008/surveillance systems, like the Oral Health Surveillance System; //2008//
- sentinel events;
- service usage;
- knowledge, attitudes and behaviors of mothers and youth; and
- treatment experience of /2008/ pregnant women and //2008// at-risk infants and toddlers.

Likewise, NYSDOH and the Title V program are able to prepare, analyze and report information about the maternal and child health population to inform needs assessment, planning and policy development, including, but not limited to:

- population demographics (age, race, ethnicity);
- populations/areas at risk and health disparities;
- socioeconomic conditions (poverty, employment, insurance coverage);
- behavioral and other health risks (teen drinking, smoking, seat belt use, drug use ***/2009/ and similar data for pregnant women //2009//***); and
- health status (morbidity and mortality rates);
- health services utilization (early trimester prenatal care, immunization coverage); and
- public perception of health problems and needs (through interaction with the public that includes block grant public hearings and focus groups).

NYSDOH maintains an active public website at www.health.state.ny.us and has additional intranet sites for state and local health department use and for the use of health providers. Our public website gets well over 32,000,000 hits annually. The Community Health Data Set is more fully described in the Needs Assessment.

Diagnosing and investigating health problems and health hazards affecting women, infants, children and youth in New York State: In addition to its normal surveillance activities, Title V and the NYSDOH maintains the capacity for conducting and have a conducted a number of special studies involving such areas as communicable diseases, childhood lead poisoning, oral health, height/weight/BMI, maternal and infant mortality, substance abuse, and smoking.

Each municipal health department in New York is required to provide local community health assessments, which are available to Title V staff and which serve as a basis for the municipalities' public health service plans and can serve as a needs assessment for counties seeking additional funds to address MCH issues.

Informing and educating the public health and families in New York State about maternal and child health issues: Title V provides the Growing up Healthy Hotline and provides for development of printed and promotional materials, media campaigns and educational experiences. (A more thorough discussion of some of DOH's recent maternal and child health related public education topics is included elsewhere in this application.) The NYSDOH website is a major source of information on health topics and provides numerous linkages to other, related sites.

Through public hearings, meetings, focus groups, libraries and web postings, we encourage the public to educate and inform the Department, as well. In this grant year, under the auspices of the Maternal and Child Health Services Block Grant Advisory Council, public hearings were again held in various locations across the State. /2008/ This year, Title V collaborated with NYMAC to complete focus groups on genetics issues.//2008// We strive to make all materials and events

culturally-, linguistically-, and age- appropriate. Consumers are paid for their time, childcare and travel expenses to participate in the focus groups. We required our contractors to provide translations services, as appropriate, and to provide nutritious, culturally-appropriate snacks.

Mobilizing partnerships between policy makers, providers, families and the public to identify and solve maternal and child health issues in New York State: The Title V agency develops and provides materials and mechanisms for dissemination of information on maternal and child health status and services, needs, and gaps in addressing needs to policy makers, health delivery systems, consumer organizations and the general public. Collaborating agencies are listed in the Needs Assessment. Collaborative efforts ***/2009/, such as the work conducted with the state's Regional Perinatal Centers and Regional Perinatal Forums to improve the quality of prenatal and intrapartum care in New York State, //2009//*** lead to the betterment of the maternal and child health population and enables access to additional populations.

Providing leadership in priority-setting, planning and policy development to support county and community efforts to assure the health of women, infants, children, youth and their families: The Title V agency has developed and promoted an MCH agenda using Healthy People 2010 and /2008/our own collaboratively-developed state health plans as our framework.//2008 The NYSDOH also provides the infrastructure/communication structures for collaborative partnerships in the development of MCH needs assessments, policies, services and programs through:

- ***/2009/ targeting of resources to address identified problems, ensuring that requests for applications require providers to design programs that meet the specialized needs of the target population served by each provider, that providers prove the need for new services in the community prior to development of new services, that a monitoring component be designed and that regular reports justifying the appropriate use of funds be sent to the Department, and lastly, that the Department modify program requirements on an as-needed basis, depending on effectiveness of particular approaches and services and/or the changing needs of the population.//2009//***
- providing routine communications (newsletters, website postings and links, technical assistance workshops, conferences, "Dear Administrator" letters, mass mailings, and, if the need arises, through a provision of in the Public Health Law called a "Commissioner's Call," which allows the State Commissioner of Health to summon the commissioner or public health director of each county to a meeting);
- convening advisory councils, task forces or workgroups composed of consumers, business, community organizations, elected officials and/or others to review health data and make recommendations;
- convening and staffing commissions and advisory councils for the oversight of maternal and child health services planning and recommending resource allocation; and
- providing funding and support for parent networks and coalitions.

It is the information gathered in performance of its essential roles and responsibilities that, taken together with knowledge of the existing trends and systems of care, form the strategic process that determines the priorities for Title V effort. /2008/ In 2007, the Title V and Preventive Health Services Advisory Councils held a joint meeting to discuss issues of mutual interest.//2008//

Promoting and enforcing legal requirements that protect the health and safety of women, infants, children and youth in New York State and to ensure public accountability for their well being: The Department works with our Office of Governmental Affairs and Division of Legal Affairs to help ensure consistency in legislative mandates, to resolve inconsistencies, to write regulations and ensure consistent policy across family and child-serving programs. Title V provides expertise in development of legislation and regulations. Title V requires contractors to adhere to all required regulations and contractual obligations and ensures compliance through program monitoring and audits. /2008/Internal Controls are tested on a routine basis.//2008// Contractors and health plans are required to regularly report on health services process and outcome measures.

To help protect the health and well being of our MCH population, New York State has a strong legislative base for:

- MCH-related governance and the organization and function of advisory bodies;
- MCH practice and facilities standards, including standards for all hospitals and freestanding diagnostic and treatment facilities, for levels of ***/2009/ not only routine but also //2009//*** high-risk perinatal care and for educational and practical preparation of health care providers;
- uniform data collection through vital records ***/2009/, the Statewide Perinatal Data System, //2009//*** and statewide registries;
- public health reporting of communicable diseases, births and deaths, child abuse and other adverse events;
- environmental protections, such as indoor smoking laws, firearms control, traffic safety, and regulations covering children's camps, temporary (farm worker) housing, use of pesticides and toxic chemicals in schools, swimming pools and bathing beaches; and
- access and quality assurance monitoring required by public insurance programs.

The Title V program in New York takes a role in development, promulgation, and regular review of statutes, regulations, standards and guidelines related to health services delivered and funded through the public and private sectors. For example, Title V worked with Medicaid to review and update a provider manual containing standards for health supervision under New York's EPSDT Program, the Child-Teen Health Program. Title V staff regularly interact in such matters with WIC, Title X, Title XIX, and Part C (IDEA). Title V staff have participated in certification, monitoring, onsite reviews and quality improvement activities of health plans and public health providers with respect to MCH services, standards and regulations. Title V staff have also been involved in review of care of children in foster care and detention services. /2008/ Title V staff are also involved with activities to improve Child Death Review.//2008// A listing of some of New York's statutes related to maternal and child health ***/2009/ formerly //2009//*** listed in Section D ***/2009/ are now shown below in accordance with Guidance instructions (previously in section IIID)://2009//***

Statutory Authority: The New York State Public Health Law provides statutory authority for various maternal and child health programs, including establishment of health departments and health care facilities and agencies, qualifications of public health officials, newborn screening, lead poisoning prevention, immunization, and health care financing.

Article 6 of the Public Health Law authorizes payment of State Aid to Localities for certain public health services, including maternal and child health services.

The New York Code, Rules and Regulations (NYCRR) interpret how Public Health Laws are to be implemented.

State Budget Bills delineate the use of State funds, including for public health and maternal and child health programs.

State Finance Law provides the requirements for management of State funds and federal funds coming through the state, and Article 7 of the Public Health Law relates to Grants In Aid.

State Education Law regulates the professions, including physicians, nurses, nurse practitioners, medical social workers, pharmacists, therapists and midwives.

Chapter 884 of the Laws of 1982 outlines the composition and responsibilities of the Maternal and Child Health Block Grant Advisory Council.

Statutory Authority for childhood lead poisoning prevention and intervention is found in Section 206 of the Public Health Law and Title X of Article 13, the Lead Poisoning Prevention Act.

Regulations are contained in Sub-Part 67-1.

Article 25 of the Public Health Law covers Maternal and Child Health, with Title I- General Provisions, Title II - Prenatal Care, Title III - Midwifery, Title IV - Institutions for Children, Title V - Children with Physical Disabilities, Title VI is expired, Title VII - Nutrition Outreach and Public Education.

The Healthy Heart Program is authorized by Article 27-B of the NYS Public Health Law. Article 27-C relates to the Birth Defects Institute, 27-D relates to Burn Care, and 27-E and F relate to HIV and AIDS.

Children's camps in New York are regulated under PHL Article 13-B.

/2009/ Emergency Medical Services for Children (EMSC) Program is authorized by Chapter 614 Article 30-C of NYS Public Health Law. EMSC Program works to expand and improve emergency medical services for children who need treatment for life threatening illnesses or injuries.//2009//

Section 2500(1) of the PHL authorizes the Commissioner to oversee care in hospitals, while section 2800 give these Department responsibility for development of state policy relative to hospitals. Both statutes authorize the Commissioner to establish standards and promote quality of maternal, child and infant health and for prevention of maternal, perinatal and infant mortality and low birth weight.

The Prenatal Care Assistance Program (PCAP) is authorized under PHL 2522. Section 85-40 in the NYCRR sets forth the regulatory parameters of the program. Comprehensive Prenatal/ Perinatal Services Networks are authorized under the legislation authorizing the Prenatal Care Assistance Program, Public Health Law 2522, which includes a provision for outreach, public education and promotion of community awareness of the benefits of preconception health care and early and continued prenatal care.

The Children with Special Health Care Needs Program is authorized by Title V of the federal Social Security Act and New York State Public Health Law 2580.

Article 27-C relates to the Birth Defects Institute, 27-D relates to Burn Care, and 27-E and F relate to HIV and AIDS.

/2009/ Public Health Law 2500-a mandates newborn blood-spot screening. //2009//

/2009/Regulations for HIV screening of newborns through the Newborn Screening Program appear in 10, NYCRR, Subpart 69-1. These HIV-related regulations were last amended in 2003, requiring a 12-hour turnaround for test results when expedited testing is conducted per regulation in the delivery setting of a delivering mother or her newborn when the mother's HIV status is not documented on presentation for delivery.//2009//

Final regulations on universal newborn hearing screening appear in Subpart 69-8 of 10 NYCRR.

Abstinence Education is authorized by Public Health Law 104-193 and the federal Personal Responsibility and Work Opportunity Act (Welfare Reform).

The American Indian Health Program is administered pursuant to Public Health Law SS 201(1)(s), under which the Department is required to "administer to the medical and health needs of the ambulant sick and needy Indians on reservations."

Comprehensive Prenatal/Perinatal Services Networks are authorized under the legislation authorizing the Prenatal Care Assistance Program, Public Health Law 2522, which includes a

provision for outreach, public education and promotion of community awareness of the benefits of preconception health care and early and continued prenatal care.

The statewide Early Intervention Program was established in Public Health Law Title II-A, Article 25 in 1992.

Family Planning is authorized under federal Title X and 10 NYCRR 42CFR, 43CFR, 45CFR, BCHS Guidelines.

Chapter 198 ***/2009/ of the Laws of 1978 //2009//*** authorizes the Health and Education Departments to certify school-based health centers and school-based dental centers.

/2009/ Chapter 170 of the Laws of 1994 authorizes the Commissioner of Health to enter into contracts for, issue operating certificates and provide funds for school-based health services operated by clinics licensed under Public Health Law Article 28 and other providers.//2009//

PHL 2500-B directs the Commissioner to provide professional and public education on Sudden Infant Death Syndrome, as well as counseling to the families affected by SIDS.

/2009/ The Childhood Obesity Prevention Program is established under Section 2599 of Public Health Law, Title VIII, for the purpose of preventing and reducing the incidence and prevalence of obesity in children and adolescents, especially among populations with high rates of obesity and obesity-related health complications including, but not limited to, diabetes, heart disease, cancer, osteoarthritis, asthma and other conditions.

Sections 903 and 904 of state education law provide for a system to assess childhood obesity throughout New York State except in the five boroughs of New York City. It places the responsibility for screening children and adolescents for weight-related disorders with the students' healthcare providers using Body Mass Index (BMI)-for-age percentiles as the standard for screening, required as of the 2008-2009 academic year. //2009//

New York has laws requiring:

- Helmets while riding bikes, scooters, ***/2009/ in-line skates,//2009//*** and motorcycles;
- Seatbelt use and passenger restraint ***/2009/ primary law //2009//***;
- 3-tiered graduated drivers license;
- Child death review by a panel that includes citizen reviewers;
- Provision of safe havens for abandoned infants;
- School district nutrition advisory committees;
- Universal newborn genetic, ***/2009/ congenital,//2009//***HIV and hearing screening and follow-up;
- Restriction of use of vaccines containing thimersol;
- Insurance coverage of child immunizations and food for special dietary usage;
- Free or reduced price lunch programs to provide food for special diets;
- Mandated reporters to report suspected methamphetamine labs; and
- A ban on purchase or use of elemental mercury in primary and secondary schools. In addition, NYSDOH recommends school inventories include location of any mercury containing products and, if found, that they be given highest priority for removal.

Pending legislation would give the Commissioner authority to train civilians in health care in the case of emergency. Also pending is a law to require all registered professional nurses practicing in New York who are educated at the diploma or associates degree level to obtain a baccalaureate in nursing within ten years of initial licensure.

Laws relating to public health are described on the Department's public website, www.health.state.ny.us/nysdoh/phforum/phforum.htm and all New York State laws and

regulations are available on the world wide web at this address: http://unix2.nysed.gov/ils/topics/laws.htm. /2008/Staff are able to link to the Office of Governmental Affairs internal website to track how health-related bills are progressing. //2008//

All necessary assurances and certifications are kept on file in the office of the Title V director and can also be found on the Department's website; www.health.state.ny.us/nysdoh/grants/main.htm

Linking women, their infants, children and youth to health and other human services and to assure access to comprehensive, quality systems of care: Title V and the NYSDOH provide a range of outreach interventions including street-level outreach and home visiting in targeted efforts to reach MCH populations that can be hard to find, hard to keep engaged and/or hard to keep in services because of their unique life circumstances (homeless women who move frequently, geographically isolated women and families, drug abusing women, and those of different languages and cultures).

DOH provides culturally and linguistically appropriate staff, resources, materials and communications, either directly or through our contractors. The availability and use of toll-free telephone information and referral lines, resource directories, public advertising and enrollment assistance greatly assists in this effort. Please see the description of the Growing Up Healthy Hotline and other health hotlines and the use of the AT&T Language Line in the Needs Assessment. ***/2009/ The Bureaus of Injury Prevention, Chronic Disease Services and Health Risk Reduction provide statewide cultural competency training annually to assist local contractors and other professionals. //2009//***

Title V monitors public response to health plans, facilities and public provider enrollment practices with respect to consumer understanding of required forms and procedures, orientation of new enrollees, and ease of access to care, and has provided assistance with identifying at-risk, or hard-to-reach individuals and in using effective methods to reach them.

Title V also provides, arranges or administers women's, children's and adolescent health services, and specialty services for children with special health care needs. We provide, generally through contractual services, those gap-filling services not generally available through health plans or mainstream benefits packages, such as school-based primary care and dental services, school-based mental health services, care coordination, public health nursing or social work, community health worker services and dental rehabilitation services. We have universal screening programs for genetic/metabolic disorders, hearing impairment, and perinatal HIV. Statute requires health care providers to screen children for childhood lead poisoning at ages one and two.

Assuring the capacity and competency of the public health/maternal and child health workforce to effectively address maternal and child health needs within the State: NYSDOH provides the infrastructure and technical capacity for efforts to ensure the competency of the public health/maternal and child health workforce training efforts.

- Title V staff serve as faculty and preceptors to the University at Albany's School of Public Health (SPH), in a unique arrangement where NYSDOH, an active State Health Department, provides the learning laboratory for SPH students.
- Title V provides paid internships and graduate assistantships to graduate students in public health to work on various research and planning projects related to Maternal and Child Health.
- Title V and other NYSDOH staff serve on the University at Albany School of Public Health's Continuing Education and Public Health Leadership Institute Advisory Councils.
- NYSDOH sponsors both a Preventive Medicine Residency Program for physicians and a Dental Public Health Residency Program for dentists.
- Title V sponsors regular satellite broadcasts on current issues in public health and maternal and child health.

- Title V sponsored Healthy Children New York, an effort that educated public health nurses and public health educators to provide consultation to child-serving agencies, such as child care providers. Staff also participate in efforts with the Office of Children and Family Services to educate child care providers in health and safety issues through their satellite broadcast system.
- Title V and NYSDOH staff work with their community partners to educate the public and providers in their area on important issues, in areas such as asthma and women's health.
- Title V staff provide workshops on community health assessment, use of data, and best practices to improve services to the maternal and child health population.
- NYSDOH recently sponsored a one-day seminar for local public health directors and county attorneys on Public Health Emergency Law, utilizing a curriculum developed by the Centers for Disease Control and Prevention.
- /2008/Title V staff participated on a national ASTHO taskforce on public health workforce enumeration.//2008//
- NYSDOH commissions studies of health workforce issues.
- /2008/ Cultural competency training and a number of other courses are available to all Title V staff linked from our intranet.//2008//
- ***/2009/ NYSDOH Division of Chronic Disease Prevention and Adult Health conducts Cultural Competency training for Health Care Professionals in NYS.***
- ***NYSDOH Bureau of Emergency Medical Services sponsors a statewide EMS Conference. This annual Conference draws more than 2000 pre-hospital care providers (EMTs, Paramedics) and emergency department clinicians. Conference workshops include topics on pediatrics including caring for children with special health care needs.//2009//***

Evaluating the effectiveness, accessibility and quality of personal health and population-based maternal and child health services: The Department regularly reviews program effectiveness and uses information to formulate responsive policies, standards and programs. DOH has the capacity to develop surveys and profiles of health status, health care access, and health care availability (types of service, provider distribution, hours of service, etc.), as well as profiles of consumer and provider knowledge, attitudes and behaviors. Programs regularly identify and report on barriers to care and collect and analyze information on community and constituent perceptions of needs within their communities. ***/2009/ Programs are routinely adjusted, sometimes on an annual basis via work plan requirements in contracts, to accommodate changes in populations, needs, or to reflect promising practices or eliminate activities with little demonstrated effectiveness. The contract mechanism, which is used to implement the majority of programs in New York State, provides a convenient mechanism to make timely adjustments on an as-needed basis. //2009//***

Title V supports a number of gap-filling direct services programs, such as the School Health Program, Preventative Dental Programs, Family Planning and the Migrant and Seasonal Farmworker Health Program. All funded programs are regularly reviewed for quality by DOH staff.

Supporting research and demonstrations to gain insights and innovative solutions to maternal and child health-related problems: Current examples of the research to gain insights and innovative solutions are the ***/2009/ maternal mortality surveillance (Healthy Motherhood) initiative, which reviews maternal deaths throughout the state, and makes recommendations that are translated into recommendations for changes in practice, //2009//*** oral health surveillance initiatives (third grade surveys and Head Start surveys), the Dental Case Management pilots and SSDI consumer focus groups. Title V also funds 14 or more graduate assistantships per semester ***/2009/ through the MCH Graduate Assistant Program //2009//***, allowing graduate students in public health to complete investigations into current research issues in maternal and child health.

NYSDOH also has an active Institutional Review Board that sponsors researcher training and

reviews all requests for vital records data, health department-related research, and registry data. Title V staff serve on this important agency review board.

The Title V agency continues to play a major role in assuring the quality and access to essential maternal and child health services in New York State. The Title V programs have worked to support the expansion of health care programs that enable women, infants and children to receive high-quality, comprehensive, appropriate services, to assure that essential maternal and child health services are strengthened by this transition, and to ensure that the public health safety net effectively and appropriately protects vulnerable populations. We do so in the context of careful, coordinated department-wide and statewide strategic planning, collaboration with other State agencies and private organizations, and State support for local communities. Our goal is to eliminate all health disparities. A list of major program objectives appears in the appendix of the application.

/2009/ Providing culturally competent approaches to provision of service delivery: The Department uses a variety approaches to promote cultural competency. As indicated in the Health Disparities section, all programs developed by the Bureaus and Divisions within the Center for Community of Health work with the communities they serve to assure that their programs meet community needs. The following processes help to ensure ongoing improvements in cultural competency:
- The Request of Applications (RFAs) process used to select contractors requires applicants to demonstrate competence in serving the target populations including linguistic and cultural competency.
- The Department provides programs with health risk data, enabling programs to tailor their programs to the community.
-Programs use community-based organizations with diverse staff, representative of the racial and ethic backgrounds of the communities.
- Programs that serve non-English speaking populations must have staff to deliver services who are fluent in the predominant foreign languages spoken in the community and/or provide access to a telephone language line.
- Written and outreach materials are translated, adapted and/or provided in alternate formats based on the needs and preferences of the population served.
-Programs actively engage the community on an ongoing basis. The School-Based Health Center (SBHC) program, for example, has a community advisory council that assures that the views of the community members are reflected in the SBHC polices priorities and plans. The Act for Youth program partners with the communities and the youth they serve to develop programs.
- Program staff receive cross-cultural competency training. The Department encouraged or sponsored the following activities:
- Family Planning providers developed and implemented cultural competency training for all contractors around the state, utilizing a curriculum developed by Family Planning Advocates in conjunction with Cicatelli Associates.
- In the perinatal arena, the Deparment's the Office of Minority Health developed a training curriculum entitled "Cross Cultural Communication" for Bureau of Women's Health contractors including Family Planning, Rape Crisis, Community Health Worker and Comprehensive Prenatal-Perinatal Services Networks programs. The workshops were designed to strengthen participants' capacity to work across cultures and in diverse communities; consider the steps necessary to establish and foster positive relationships; make the connection between communication and culture; and apply cultural competency models.
- In June of 2008, Bureau of Women's Health Regional Perinatal Center contractor, Albany Medical Center hosted training entitled "Transcultural Education: A Journey to Cultural Proficiency," The training included didactic discussion and group activities and reviewed perinatal conditions in which disparities in heath outcomes are due to race, ethnicity or culture. The training was designed to help practitioners become more aware of their own cultural values, beliefs and practices and how this affects interaction with others. The

training was open to nurses, physicians and others who interact with families during pregnancy and childbirth. The training is a program of the National Perinatal Association and was developed with the interest of reducing disparities in perinatal health outcomes. This training has also been used by the Bureau's Comprehensive Prenatal-Perinatal Services Networks contractors.

Recognizing that State and local Department of Health's staff also need to improve their cultural competency, the Department's Office of Minority Health offers training and a cross-cultural communication toolkit and that is available to the government staff responsible for RFP development, program design, monitoring of activities, and program evaluation. This training and toolkit enables participants to make connections between communication and culture; enhances awareness, knowledge and application of cultural competency models; addresses techniques and standards; addresses cross-cultural communication strategies. This training also increases awareness about the impact of health disparities on racial and ethnic populations. As mentioned earlier in the document, staff have used other training venues such as the New York--New Jersey Public Health Training Centers.

It is important to note the role played by the Office of Minority Health (OMH) and the Minority Health Council (located within the Center for Community Health). OMH and the Council provide leadership, expertise and technical assistance for all New York State Department of Health programs. Created by an amendment to the public health law in 1992, the Office of Minority Health's mission is to promote, and serve as the department's focal point for, minority health matters. The Office accomplishes this mission by working with departmental programs, other federal, state and local government agencies, and community organizations. The Office's responsibilities include minority clinical training and curriculum improvement as well as other functions (community strategic planning, improved health care delivery systems/networks in minority areas; impact reviews of programs, regulations, and health care reimbursement policies on minority health services, delivery and access, etc).
- Further, the Department recognizes that healthy communities are communities that honor differences, consider all community members as assets and celebrate diversity. The Department is committed to addressing disparities in health care and promoting strategies to resolve them. The Health and Human Services for Lesbian, Gay, Bisexual and Transgender Individuals and their Support Systems Initiative focuses on addressing disparities through building a wider, more sensitive and appropriate system to promote health and wellness for lesbian, gay, bisexual and transgender (LGBT) individuals, their families and support systems. Activities center on development of community-based initiatives that present a variety of opportunities to enhance the health and human service system that LGBT individuals encounter in their communities.//2009//

C. Organizational Structure

/2009/ Summary: As previously stated, the organizational structure of the Department was modified in early 2008 to put even further emphasis on preventive and community health, and this will be discussed in greater detail in the 2008 report. The state continues to maintain a significant public health infrastructure, including both Bureaus and Programs devoted exclusively to maternal and child health, and a significant array of other programs that address these populations for specific health issues.

As previously stated in the Needs Assessment, the responsibility for New York's Title V Program is located within the New York State Department of Health, Center for Community Health, Division of Family Health, which is "responsible for the administration (or supervision of the administration) of programs carried out by Title V." [Section 509(b)]

/2008/The New York State Department of Health is an executive agency, with Commissioner Richard Daines, MD, reporting /2009/ previously //2009// to Governor Eliot Spitzer ***/2009/ and now to Governor David Paterson, //2009//*** through Secretary for Health Dennis Whalen, our former Executive Deputy Commissioner.//2008//

- Maternal and child health programs are located throughout the Department, but are mostly located in the Center for Community Health and the Division of Family Health, where administrative oversight for the Block Grant is vested. ***/2009/ As will be described in more detail in the 2008 report, as appropriate, there was a significant change in organizational structure of the Department in early 2008, with re-creation of the Office of Public Health, which oversees the vast majority of programs and initiatives reported in this document. Dr. Guthrie Birkhead was appointed, at the Deputy Commissioner level, to head the Office of Public Health, and Ellen Anderson was appointed to fill his former role as Director of the Center for Community Health. //2009//*** In addition to its responsibility for Title V, the Division of Family Health is responsible for family planning (Title X), early intervention (Part C/IDEA) services, the Prenatal Care Assistance Program, perinatal networks, designation of perinatal centers and CSHCN specialty centers, ***/2009/approval and oversight of school-based health centers, //2009//*** dental health, lead poisoning prevention, adolescent health, youth development, adolescent pregnancy prevention, universal newborn hearing screening and programs for children with special health care needs, ***/2009/ as well as the state's Growing Up Healthy Hotline, which provides referrals to these and other programs to all residents of New York State, 24/7, in English and Spanish, with other languages available, and with a TTY line for the hearing impaired. //2009//***

The State Health Department's organizational chart is included with this submission in the Appendix. Organizational structure and staffing support our mission, vision and values.

Division of Family Health has four Bureaus:

- The Bureau of Child and Adolescent Health;

Title V and Title V-related programs within the Bureau of Child and Adolescent Health include: Childhood Lead Poisoning Prevention, Children with Special Health Care Needs (including the Family Specialist), the Physically Handicapped Children's Program, Youth Development, the School Health Program, the Coordinated School Health Initiative, ACT for Youth, Abstinence Education ***/2009/ (discontinued effective 9/30/07) //2009//***, the Community-Based Adolescent Pregnancy Prevention Program, Interim Housing for Lead Poisoned Children and their Families, the Regional Lead Poisoning Resource Centers, and the Gay, Lesbian, Bisexual and Transgendered Youth Initiative. BCAH also has responsibility for the Early Childhood Comprehensive Services Initiative.

- The Bureau of Dental Health;

Title V and Title V-related programs within the Bureau of Dental Health include Dental Public Health Education, the Preventive Dentistry for High-Risk Underserved Children's Program/Dental Sealant Program, the Fluoride Supplementation Program, the Dental Public Health Residency Program, Oral Health Surveillance and Dental Research, the Dental Rehabilitation (Orthodontia) Program, the Statewide Oral Health Technical Assistance Center, and School-Based Dental Services.

- The Bureau of Early Intervention Services; and

The Bureau of Early Intervention Services administers the Part C/IDEA programs and the Universal Newborn Hearing Screening Program. This Bureau is also responsible for publication of "Welcome to Parenthood," a publication received by all new mothers delivering in any of New

York State's hospitals.

- The Bureau of Women's Health.

Title V and Title V-related programs within the Bureau of Women's Health include the Family Planning Program/Title X, ***/2009/ which includes the Infertility Prevention Program, as well as the Family Planning Benefit Program and the Family Planning Extension Program, //2009//***the Growing Up Healthy Hotline, the Community Health Worker Program, ***/2009/ the Universal Prenatal and Postpartum Home Visiting Program, the //2009//*** Comprehensive Prenatal/Perinatal Services Networks, the Prenatal Care Assistance Program (PCAP) and the Medicaid Obstetrical and Maternal Services (MOMS) Program, the Lactation Institute, the Preventive Medicine Residency Program, the Coordinated Women's Health Program, the Osteoporosis Program and Advisory Committee, Maternal Mortality Review, ***/2009/ the Infertility Demonstration Program, //2009//*** and the Statewide Perinatal Data System, and responsibility for designation of all birthing hospitals for perinatal services level. BWH also works with the AIDS Institute on the Community Action for Prenatal Care (CAPC) Program. ***/2009/ The Preventive Medicine Residency Program now is co-managed by its longtime director, Dr. Mary Applegate, who is currently at the School of Public Health, with on-site management by Dr. Debra Blog, Medical Director of the Immunization Program.//2009//***

The Division of Family Health directly administers the State Systems Development Initiative (SSDI), the American Indian Health Program, the Columbia Collaborative Public Health Education Project, the Asthma Collaborative, and Migrant and Seasonal Farmworker Health Services. Genetics Services and the Newborn Metabolic Screening ***/2009/ (blood spot) //2009//*** Program are administered by NYSDOH's Wadsworth Laboratories. The Congenital Malformations Registry is located within the Center for Environmental Health. A more complete description of the agency's capacity appears in the Needs Assessment.

An attachment is included in this section.

D. Other MCH Capacity

The Division of Family Health continues responsibility for coordinating MCH-related programs and directly managing many MCHSBG-funded initiatives. /2008/ Overall, there are currently 213 filled Title V-funded positions within the NYSDOH and an additional 630 non-Title V-funded positions performing Title V-related activities. Positions are located within the Department's central, regional and district offices. Staff cover the full range of MCH activities, including child and adolescent health, women's health, perinatal health, dental health, local health services, nutrition, child safety, injury control, laboratory operations, human genetics, congenital malformations, data and information systems infrastructure, health communications, managed care and facility surveillance. //2008//

/2009/ Barbara McTague is the Director of the Division of Family Health and Director of the New York State Title V Maternal and Child Health Services Program in the New York State Health Department. Ms. McTague provides policy and program direction and administrative oversight for the Division's bureaus, including the Bureau of Women's Health, the Bureau of Child and Adolescent Health, the Bureau of Dental Health, the Bureau of Early Intervention and the Migrant and Indian Health. Employed by the New York State Department of Health since 1987, she has managed several programs and Bureaus within the Department. While in the AIDS Institute, she developed, implemented and managed a number of innovative, new public health programs related to the prevention and treatment of HIV, including: the AIDS Drug Assistance Program, women's HIV counseling, testing and supportive services, the Substance Abuse Initiative, which provides the full continuum of HIV services in substance abuse treatment settings, including the development of needle exchange programs. In 1996, Ms. McTague became

the Director of the Department's new Bureau of Women's Health, where she managed the statewide family planning program, including development and implementation of Medicaid waiver programs to expand access to family planning services, as well as Department's initiatives related to adolescent pregnancy prevention. In addition, she developed programs related to violence against women, including standards of hospital care for victims of sexual assault. Ms. McTague also spearheaded a perinatal regionalization initiative which resulted in significant changes in the perinatal health services arena, including the development of a statewide perinatal data system and significant improvement in the regionalized system of perinatal care. Ms. McTague has also directed the Bureau of Early Intervention, the statewide service delivery system for toddlers with disabilities. During her tenure, Ms. McTague led a significant effort to clearly articulate program policies and goals and to standardize and improve the quality of program performance. Ms. McTague has made considerable contributions to improving the health of women, children and adolescents throughout New York State.

Wendy Shaw, R.N., was appointed as Associate Director of the Division of Family Health in August, 2007 following the retirement of Dennis Murphy. Wendy had been serving as the Director of the Bureau of Women's Health since the retirement of Barbara Brustman in January of 2007. She maintains her clinical skills as a labor and delivery nurse by actively practicing at a local area hospital. Wendy served as Director of the Perinatal Health Unit within the Bureau of Women's Health from 2000 through 2002, when she became Assistant Director of the Bureau of Women's Health. Her previous state experience in the Early Intervention program provides her with further valuable knowledge in her new role within the Division of Family Health.

Within the Director's office, Barbara A. Brustman, Ed.D., coordinates MCHSBG-grant application development and submission, grant management activities and special projects. Dr. Brustman received her doctorate from Columbia University and has worked for the Department of Health in various maternal and child health programs for over 27 years, all within the Division of Family Health. She served as Director of the Behavioral Science section of the Bureau of Dental Health, as Head of the Research and Development Section of the Planning, Development and Evaluation Unit, Director of Research and Evaluation of the Perinatal Health Unit, Director of the Perinatal Health, and finally Director of the Bureau of Women's Health. She has served as Principal or Co-Principal Investigator on studies such as the PRAMS project, and recently the Perinatal Depression initiative. She was a longstanding member of the Center for Community Health's Survey Review Committee. Barbara has recently retired from full time service, and has undertaken MCHSBG application development on a part time basis.

In 2006, the Division of Family Health established an Office of the Medical Director to bring clinical expertise to the Divisions broad array of programs. This office under the direction of Marilyn Kacica, M.D., M.P.H., provides leadership and collaborates closely with the Bureaus in the Division. In April of 2006, Marilyn Kacica, M.D., M.P.H. was appointed Medical Director of the Division of Family Health. Dr. Kacica is a graduate of St. Louis University and received her M. D. from the St. Louis University Medical School. She completed pediatric residency training at the Cardinal Glenon Children's Hospital, subspecialty training in pediatric infectious disease at the Children's Hospital of Cincinnati, and her preventive medicine residency at the New York State Department of Health. Her M.P.H. was awarded from the State University of New York at Albany, School of Public Health, where she is currently a Clinical Associate Professor of Epidemiology. She is board certified in Pediatrics. Prior to moving to the Division of Family Health, she served as the Director of the Healthcare Epidemiology Program in the Division of Epidemiology's Bureau of Communicable Disease Control. She is providing leadership on a myriad of clinical, epidemiological, data utilization and quality improvement issues within the Division. She is currently serving on the AMCHP Emergency Preparedness Committee as well as the Emerging Issues Committee and leads preparedness efforts

being made on behalf of New York's maternal and child health population. Dr. Kacica serves as the Principal Investigator (PI) to the State Systems Development Initiative. In addition Dr. Kacica is the Program Director for the New York State Department of Health's Child Health Integration Initiative.

Christopher Kus, M.D., M.P.H., serves as Associate Medical Director for the Division of Family Health, and is a pediatric consultant to the Division. He is a graduate of Michigan State University and the Wayne State University School of Medicine. He received an M.P.H. from University of North Carolina at Chapel Hill. He is a developmental pediatrician who has worked with the New Hampshire and Vermont Departments of Health prior to coming to New York. He has been with the New York State Department of Health for over ten years. Dr. Kus is Past President of the Association of Maternal Child Health Programs (AMCHP). He has chaired their committee on Service Delivery and Financing Systems and co-chaired the MCH-Medicaid Technical Advisory Group.

Patricia Waniewski, M.S., R.N. is the Asthma Coordinator for the New York State Department of Health (NYSDOH), providing leadership for coordinating, implementing and evaluating the New York State Asthma Plan. She received her Bachelor of Science degree in nursing from Villanova University and her Master of Science degree in Medical and Surgical Nursing and Health Systems Administration from Russell Sage College. She has been working in the health arena as a clinician, administrator and educator for the past 30 years, primarily in community and ambulatory health care services, and more recently in public health. She represents the NYSDOH Asthma Program on asthma related issues at the Centers for Disease Control and Prevention (CDC) and on other national and state workgroups. Prior to her public health role, she directed a regional Ambulatory Care Network where she designed, implemented and evaluated systems, programs and services in response to the diverse needs of urban, suburban and rural communities with a focus on quality improvement. From 1974 --1994, Pat served on active duty and in the Naval Reserve as a Nurse Corps Officer.

Marianne Heigel, R.N., is the Regional Asthma Coalition Coordinator within the Division of Family Health, New York State Department of Health. She provides contract management oversight and technical assistance to the eleven regional asthma coalitions. Her other public health experience with the Department includes monitoring public health outcomes in Child and Adolescent Health, Communicable Disease Control and a NIH Lead study with Environmental and Occupational Health. Prior to her career with the NYSDOH, she also worked in the hospital setting in upstate NY as an RN in the coronary care unit and operating room. She received her Associates Degree in nursing from Maria College. //2009//

Wendy Stoddart, R.N. serves as Program Director of the American Indian Health Program. Ms. Stoddart works with primary care contractors throughout the state and the Nations' clinic staff to ensure that the Native American nations across the state have access to primary health care services, preventive health education, pharmacy, eye care and home care services. Ms. Stoddart is a member of the workgroup charged with sheltering of special populations in an emergency event. Wendy Stoddart R.N. is a former Director of Patient Services for St. Lawrence County Public Health Department. She has over (almost) 30 years of experience planning and implementing preventive health programs. She is working with Dr. Marilyn Kacica on the NYS DOH preparedness document for pediatric and obstetrical populations. She also is a member of the NYS Sheltering task force working with special needs populations.

Thomas Carter, Ph.D., continues to coordinate the cross-systems, cross-agency partnerships for the Department, and serves as the coordinator of the NYS Youth Development Team, a state-level, public/private collaboration focused on improving health, education and other outcomes for youth. Dr. Carter also coordinates the MCH Graduate Assistant Program, which matches priority MCH projects with graduate students from the School of Public Health, University at Albany, and

directs the Migrant and Seasonal Farmworker Health Program, which provides access to high quality, culturally and linguistically appropriate health and social support services to improve the health status of this important, vulnerable population.

The Child Morbidity and Mortality Prevention Program, formerly in the Bureau of Child and Adolescent Health, is now located within the Office of the Medical Director. James Raucci heads this project. Mr. Raucci also works with Ms. Stoddart on special needs sheltering issues and manages the Enhanced Services for Children and Youth program.

In 2007, New York's State Systems Development Initiative (SSDI) grant, coordinated by Ms. Cathy Tucci-Catalfamo was relocated to the Office of the Medical Director. The goal of the SSDI grant is to foster an infrastructure to improve data linkages among multiple data sources for child health information to assure program and policy development for material and child health.

Rachel de Long, M.D., M.P.H., has served as the Director of the Bureau of Child and Adolescent Health at the New York State Department of Health since 2005. Prior to this role she served as the Bureau's Medical Director from 2003 to 2004. Dr. de Long also serves on the faculty of the SUNY at Albany School of Public Health in the Department of Health Policy, Management, and Behavior. She earned a B.S. in Rural Sociology from Cornell University, M.D. from University of Wisconsin Medical School, and M.P.H. from SUNY Albany School of Public Health. She completed a medical internship in Family Practice at the Guthrie Clinic and residency training in Preventive Medicine at SUNY Albany/NYS Department of Health, and is Board Certified in Preventive Medicine and Public Health. As Bureau Director, she has overall responsibility for developing, implementing and evaluating policies and programs related to a range of child and adolescent health issues. She serves as Principal Investigator for several major child health related federal grants.
Elmer Green, DDS, MPH, has been the Director of the Bureau of Dental Health since 1985. Prior to that, he served as the Assistant Director of the Bureau of Dental Health from 1974-1984 and as a regional public health dentist in the Department of Health. Dr. Green earned his undergraduate and dental degrees from Howard University in Washington, D.C. and has a master's in public health from the University of Michigan. As the Bureau Director, Dr. Green oversees the Department's public health dental programs targeting high-risk underserved women and children, the supplemental fluoride program for preschool and school-aged children residing in non-fluoridated areas of the State, the Dental Rehabilitation Program for children with congenital or acquired physically-handicapping malocclusions, and the Preventive Dentistry Program for Deaf/Handicapped Children in conjunction with Bellevue Hospital in New York City. Other Bureau activities and programs include Dental Health Education, the Dental Public Health Residency Program, research and epidemiology, the oral health initiative, and targeted oral health service systems for women and children.

Brad Hutton received his Bachelor of Arts from Columbia University and his Master's of Public Health from the University at Albany School of Public Health, where he has also completed all requirements except the dissertation for a Ph.D. in epidemiology. He has been with the New York State Department of Health for fourteen years, serving as the Director of its Bureau of Early Intervention for the last year and a half. As Director, Brad oversees a team of 50 staff with responsibility for the administration of New York's Early Intervention Program which serves more than 70,000 infants and toddlers with disabilities or developmental delays each year. Previously, Brad directed the Department's Cancer Services Program for six years. He has served on several committees that advise the Centers for Disease Control and Prevention on cancer control and also served on the Institute of Medicine's Committee to Improve Mammography Quality due to his leadership role in identifying and improving the quality of mammography in New York.
//2009//

E. State Agency Coordination

The New York State Department of Health has formalized relationships with other state agencies, local public health agencies, federally-qualified health centers, tertiary care facilities, academic institutions and the non-profit voluntary sector, which all enhance the capacity of the Title V program to utilize state health status indicators to provide information on the State's residents, assist in directing and targeting public health measures, note trends and conditions of the population and function as evaluative measures.

Agreements with Other State Agencies
State agencies are coordinated at the level of the Governor's cabinet. The Department of Health is a party to several written agreements or memoranda of understanding with other state agencies. These agreements serve to formalize collaborative activities between DOH and partner agencies.

- The State Education Department is not an executive agency in New York, but a constitutional body, not under the Governor nor the Legislature. The State Education Department (SED) is responsible for general supervision of all educational institutions in the State, for operating certain educational and cultural institutions, for certifying teachers, and for certifying or licensing practitioners of thirty-eight professions. The department's supervisory activities include chartering all schools, libraries and historical societies; developing and approving school curricula; accrediting colleges and university programs; allocating state and federal financial aid to schools; and providing coordinating vocational rehabilitation services.

- The State Education Department administers the Youth Risk Behavior Surveillance System with NYSDOH collaboration. NYSDOH also collaborates with the Education Department on issues such as placement of automated external defibrillators in schools, administration of fluoride rinse programs, issues related to the healthcare/public health workforce, scope of practice issues, transition from early intervention to preschool programs, and approval of school-based primary care and dental care centers.

- The Department has a Memorandum of Understanding with the State Education Department regarding school health infrastructure and coordination. This memorandum supports the statewide implementation of comprehensive school health and wellness. Comprehensive School Health and Wellness Centers help school districts across the State create positive learning environments for their students. Schools that model and encourage students to engage in healthy behaviors create an atmosphere for academic success and individual growth.

- As the lead agency for the Early Intervention Program, the Department has letters of agreement with the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the State Education Department, and the Office of Alcohol and Substance Abuse Services related to the implementation of this program.

- The Office of Children and Family Services also administers the Adolescent Pregnancy Prevention and Services (APPS) Program, providing prenatal support and parenting education to high-risk teens in high need communities. ***/2009/ Effective in 2008, this program will be administered by the Department of Health in order to improve coordination of all adolescent pregnancy prevention efforts.//20009//***

- ***DOH Title V staff work with the Office of Children and Family Services on health care of children in foster care and on issues related to the health and safety of infants and children in child care. The Early Intervention Program collaborated with OCFS in the development of a guidance document entitled, "Protocols for Children in Foster Care Who Participate in the Early Intervention Program."***

- ***/2008/Title V staff work with the Office of Children and Family Services on new parameters for child death review. (See page 33 of the Needs Assessment for a full***

explanation of recent changes.) //2008//

- ***The State Legislature allocated funding from the federal Temporary Assistance to Needy Families (TANF) Block Grant to the Department of Health for outreach and education activities to prevent unintended pregnancies and for School Health. The Department has entered into a Memorandum of Understanding with the Office of Temporary and Disability Assistance to provide for the transfer of these funds to the Department. This office is also the lead agency for the Teenage Services Act (TASA) Program, providing services to pregnant and parenting teens on Public Assistance.***

Other State Agency Collaborations

- ***The Touchstones Initiative, with the Council on Children and Families as the lead agency, began as a collaborative of 13 New York State agencies that fund programs for children and families. State agencies were challenged to agree on the benefits of funded services in clear, consistent, measurable terms. The Team established a Kids Wellbeing Indicator Clearinghouse (KWIC) on the Internet, the purpose of which is to make vital youth statistical information more timely, accessible and usable to communities.***

- ***The New York State Youth Development Team is a partnership established in 1998 by more than two dozen public and private organizations. The partnership has lead efforts to develop and promote youth development strategies across health and human services systems in New York State. Agency team members include all major state agencies serving youth (health, mental health, education, public assistance, juvenile justice, substance abuse, /2009/ labor //2009//***), as well as the New York State Nurses Association, Cornell University, the YMCA, the NYS Association of Youth Bureaus, the Mount Sinai Adolescent Health Center, the Association of Family Services Agencies, the NYS Center for School Safety, University of Buffalo, Families Together of NYS, University of Rochester, the Schuyler Center for Analysis and Advocacy, the Conference of Local Mental Hygiene Directors, and the NYS Counseling Association. The Team's vision is for families, schools and communities partnering to support the development of healthy, capable and caring youth. ***/2009/ Recent changes to the team's configuration include loss of Mount Sinai and University of Buffalo, and addition of the School of Public Health at the State University of New York at Albany, and Children for Children, NYS After School Network, and United Way of NYS. //2009//***

The Youth Development team, co-chaired by DOH and OCFS, has guided the creation of several cutting edge products, events and initiatives, including a resource notebook. /2008/ For more details, see the Partners for Children/Youth Development website at: http://www.nyspartnersforchildren.org/teen.htm//2008// ***/2009/ Additional products of the NYS Youth Development team include a Journal Supplement focused solely on youth development (i.e., Journal of Public Health Management and Practice, Nov. 2006). Web site access has been updated to the following sites: http://www.health.state.ny.us/community/youth/development/ and the Cornell University ACT for Youth website http://www.actforyouth.net/. //2009//***

- The Coordinated Children's Services Initiative (CCSI) is a cross-systems process for serving children with special emotional and behavioral services needs that builds upon legislation enacted in 2002. The process utilizes strength-based approaches, consistent and meaningful family involvement, individualizing planning, and encourages creative, flexible decision-making and funding strategies. CCSI Statewide Partners are: Family Representatives, Office of Mental Health, State Education Department, Office of Children and Family Services, Council on Children and Families, Division of Probation and Correctional Alternatives, Office of Mental Retardation and Development Disabilities, Department of Health, NYS Commission on Quality of Care and Advocate for Persons with Disabilities, and the Developmental Disabilities Planning Council.

Priority areas for CCSI include the development and delivery of training and technical assistance related to building and sustaining local systems of care, including a family advocacy training

curriculum. CCSI continues to work to implement the comprehensive set of recommendations for improving services for children who have cross-systems needs (developed in 2004).

• The goal of Family Support New York is to transform public/private systems and services to support and foster empowerment of families in New York State. The Council on Children and Families is the lead agency. Other members include the Department of State, the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Family Development Association of New York State, Family Support NYS, and various community and parent representatives.

• The NYS Developmental Disabilities Planning Council (DDPC) is seeking to develop more non-segregated socialization opportunities (beyond one-time events) for youth with and without disabilities, through a statewide technical assistance and capacity building model. DDPC will issue a competitive Request for Proposals targeting a statewide entity such as the YWCA, Boy Scouts, Girl Scouts, etc. to serve as an umbrella organization that will provide information, skill-building, and technical assistance to build capacity within schools and "chapter" organizations of the chosen statewide entity to facilitate the development of friendship and socialization between youth with and without disabilities.

• In effort to address the issue of successful health care transitioning, the NYS Developmental Disabilities Planning Council (DDPC) established an Institute for Training on Health Care Transitioning. The Institute is developing statewide expertise on youth with developmental disabilities, age 14-25, as they transition from pediatric to adult health care, caregivers who support the transition and primary care physicians who are integral to making a successful transition. The Institute will develop three interrelated curricula on health care transitioning including:

a) Curricula for primary care medical providers, covering information such as: understanding and recognizing disabilities, understanding developmental aspects of disabilities, providing accommodations including physical, sensory and other disability related issues.

b) Curricula for individuals with developmental disabilities covering information such as: developing a relationship with adult medical providers, asking questions and sharing relevant information with adult health care providers, keeping track of and sharing medical history.

c) Curricula for caregivers covering information such as: planning for transition to adult health care providers, locating and interviewing adult health care providers, decision making issues after the child turns 18.

/2009/The Department of Health is collaborating with the Developmental Disabilities Planning Council (DDPC) to support the successful transition of youth with special needs to adult learning, earning and independence. //2009//

/2008/ The new Youth Advisory Council is making recommendations to DOH relative to transition issues. (See description on pages 7-8 of the Needs Assessment.) //2008//

Other Collaborations --

• Healthy Start: Many of the federal Healthy Start grantees are also grantees of New York State Department of Health under the Comprehensive Prenatal/Perinatal Services Network initiative. The Networks were initially funded under Title V, but have now moved onto a different source of funding. However, the need for close association with Title V programs continues in order to maximize mutual effectiveness. The Department holds periodic meetings (at least two per year) with Healthy Start grantees in order to foster better communication, explore areas for potential collaboration and share late-breaking developments. The Healthy Start consumer group assisted Title V in evaluating focus group methods and provided feedback that will be

incorporated in planning for the next wave of consumer focus groups. /2008/The April 2007 meeting focused on successful social marketing. //2008// Regional staff also meet with the Networks on a routine basis.

- ***/2009/ The Comprehensive Prenatal/Perinatal Services Networks collectively have formed the Association of Perinatal Networks (APN) that meets regularly with the Department of Health. //2009//***

- Local Health Departments: County health departments continued to play an essential role in the assurance of high-quality, accessible maternal and child health services. They assessed the needs of their local communities, worked with their communities to design and implement programs that meet those needs, and evaluated the effects on their communities.

Under Article 6 of the New York State Public Health Law, local health departments extend the powers of the state health commissioner. Under Article 6, local health departments perform comprehensive community health assessments, and subsequently produce a Municipal Public Health Service Plan. Plans address the needs of the maternal and child health population in health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury control, disease control and nutrition. Title V provides technical assistance to local health units in plan development, participates in the review process and monitors implementation. of the plans. Because local health departments know local systems and community needs, plans address coordination across public and private resources, and across the continuum of primary, secondary and tertiary care. Local health units play a critical role in fostering local collaborations and locally addressing disparities in health outcomes.

- ***/2009/ New York State also partners closely with the American College of Obstetricians and Gynecologists, District II, on a number of maternal initiatives, including the Maternal Mortality/Safe Motherhood initiative, which attempts to identify each maternal death in New York State and use reviews of these deaths to help inform policy decisions, in conjunction with the Department of Health. In addition, this collaboration leads to training initiatives that are implemented across the state to improve the hospital-based and prenatal care of pregnant women.//2009//***

- New York State has a long-established system of highly specialized Regional Perinatal Centers (RPCs). These Centers provide tertiary level clinical care to high-risk mothers and newborns, and also serve as important contact points for the Department of Health in our interactions with the health care community. They help ensure that high-risk mothers and newborns receive appropriate levels of care by working with their affiliate hospitals to monitor perinatal morbidity and mortality and to provide education and technical assistance to physicians and others. The Regional Perinatal Centers not only serve as the hub for consultation and transport within a network, but lead quality improvement activities within their network. All birthing hospitals in the state, including Regional Perinatal Centers, were reassessed and redesignated in 2001. ***/2009/ The Regional Perinatal Centers (RPCs) are represented by the Association of Regional Perinatal Programs and Networks (ARPPN), which meets with the Department regularly for purposes of planning and quality improvement.***
- ***The Prenatal Care Assistance Program (PCAP) provides comprehensive prenatal care services to women under 200 percent of the Federal Poverty Level, and these providers are reimbursed at a higher rate for these more comprehensive prenatal and related services. PCAP providers are comprised of more than 134 different agencies, providing care at more than 400 sites statewide. In addition to the improved access to comprehensive prenatal care for low income women, one of the most important features of PCAP is that women not enrolled in Medicaid prior to pregnancy can be screened for eligibility by these prenatal care providers, and if "presumptively eligible" can begin services immediately. Providers assist women to complete application forms for Medicaid, and are authorized to submit these forms to the local social services office, which in turn does not require these women to have a face-to-face encounter with social***

services staff.

Outreach to enroll pregnant women in prenatal care is conducted locally by the Comprehensive Prenatal-Perinatal Services Networks, the Community Health Worker Program, or, when implemented, the Universal Prenatal and Postpartum Home Visiting Program, where available, as well as through coordination conducted by the local PCAPs with other area service providers, locally-conducted outreach activities, and statewide outreach campaigns, which are conducted periodically.

- ***New York State provides the vast majority of services through contracts with community-based providers, including hospitals, diagnostic and treatment centers, community-based organizations, colleges and universities, etc. These contracts are specific about the services to be provided and the outcomes expected. However, all of the nearly 750 contracts maintained by the Division of Family Health that perform Title V or related services represent a collaboration between the contractor and the State Department of Health to provide high quality services to the people of the state, and the commitment of our contractors to serving the public is extraordinary. The interactions of the Department with our service providers represents an ongoing collaborative relationship of the highest order on behalf of the state's medically needy.//2009//***

- Area Health Education Centers (AHECs) work to recruit, retain, and support health professionals to practice in communities with health provider shortages, developing opportunities and arranging placements for future health professionals to receive their clinical training in underserved areas, and providing continuing education and professional support for professionals in these communities. They encourage local youth to pursue careers in health care. The MCH Advisory Council, the State Health Department and the AHECs are mutually concerned about the aging of the health care workforce; the aging of nursing and dental faculty; current and future shortages in certain key health professions; and in interesting young people in health careers early in their student careers. The Bureau of Dental Health is working with AHECs and local rural health networks to improve access to primary dental care in rural areas.

- The University at Albany School of Public Health is unique in that it is jointly sponsored by the university and our state health department. The New York State Department of Health serves as the laboratory for the University at Albany School of Public Health, with graduate students working shoulder-to-shoulder with practicing professionals in the state health department or in local departments. A number of DOH and Title V staff serve as faculty and advisors to the school. Title V staff also serve on the School's Continuing Education Advisory Board and on the advisory council for the North East Public Health Leadership Institute. ***/2009/ The Bureau of Women's Health maintains a health education contract with the SUNY School of Public Health that facilitates calling upon the resources of the school for training and education of professionals, such as family planning providers, prenatal care providers, etc. In the past several years, training of health care professionals, including front line workers, in recognizing signs of domestic abuse was held in all regions across the state by the school, and repeated in the following year. Four sessions on Cross Cultural Communication intended for family planning, rape crisis and community-based providers were held to aid participants in strengthening their capacity to work across cultures and in diverse communities. //2009//***

- Title V staff coordinate the MCH Graduate Assistant Program, under which fourteen University at Albany graduate students per semester (fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning projects. This arrangement supports the Department of Health's mission through attracting bright, motivated individuals who are interested in gaining theoretical and practical knowledge of public health and maternal and child health. The relationship with the University enhances the Department's research capacity, and improve the availability of pertinent and timely educational offerings for practicing public health professionals in the region. The arrangement also enhances NYSDOH's ability to hire

stellar students from diverse backgrounds whose performance on public health projects has already been evaluated during their internships ***/2009/ and field placements. //2009//***

- The University at Albany's School of Public Health sponsors the Northeast Public Health Leadership Institute (NEPHLI), now serving the northeast corner of the US. Several Title V staff have attended the Institute. Several graduates of the Institute also serve Title V in other states and at the New York City Department of Health. Title V staff and Dr. Birkhead serve on their advisory council.

- The Department also maintains a relationship with the Columbia University School of Public Health through a Collaborative Studies Initiative. Metropolitan Area Regional Office staff serve as advisors and contract managers to the program. Columbia students and public health faculty identify current issues in maternal and child health, and apply public health theory and practice in designing and implementing solutions to those issues. As a result, several projects in very high needs areas of New York City have been planned, implemented and evaluated. Students are required to submit their projects to peer-reviewed journals and to present at national meetings.

- New York has three University-Affiliated Programs who offer Leadership Education in Neurodevelopmental Disabilities (LEND). They are the University of Rochester, the Westchester Institute at Valhalla, and Jacobi/Albert Einstein Medical Center. LEND Programs provide for leadership training in the provision of health and related care for children with developmental disabilities and other special health care needs and their families. The Department works with the LENDs on a variety of issues related to children with special health care needs and to meet training needs, and the University Affiliated Programs are a great source for physician consultants on a variety of issues. Several LEND fellows ***/2009/ and faculty //2009//*** recently traveled to Albany to meet with Title V staff in the Division of Family Health and to discuss their recent research ***/2009/ as well as to learn about the Department's MCH initiatives.//2009//***. Several LEND fellows attended an orientation to Title V sponsored by the New York Medical College, School of Public Health.

- Title V and the Adolescent Coordinator maintain linkages to the Leadership Education in Adolescent Health (LEAH) Program at the University of Rochester. The purpose of LEAH is to prepare trainees in a variety of professional disciplines for leadership roles in the public and academic sectors and to ensure high levels of clinical competence in the area of adolescent health. Training is given in the biological, developmental, emotional, social, economic and environmental sciences, within a population-based public health framework. Prevention, coordination and communication are stressed.

- Healthy Tomorrows Partnership for Children is a collaboration between HRSA and the American Academy of Pediatrics (AAP) formed to stimulate innovative programs in areas of limited health care access and high need. In May 2006, Title V staff from the Bureau of Dental Health accompanied AAP on a Technical Assistance visit to the project at the University of Rochester Medical Center, the Dental Home for Children Project. This project targets children with significant dental needs to address barriers to service and other related issues. The project also seeks to improve communication between primary care providers and dentists.

- New York's Pediatric Pulmonary Center is located at Mount Sinai Medical Center in Manhattan. The Pediatric Pulmonary Center takes an interdisciplinary approach to developing health professionals for leadership roles in the development, enhancement or improvement of community-based care for children with chronic respiratory diseases and their families. In addition serving as a model of excellence in interdisciplinary training, Mount Sinai also engages in active partnership with state and local health agencies and provides model services and research related to chronic respiratory conditions in infants and children.

- Montefiore Medical Center sponsors the Behavioral Pediatrics Training Program. Training

grants from the Federal Maternal and Child Health Bureau support faculty who demonstrate leadership and expertise in the teaching of behavioral pediatrics, scholarship and community service. Fellows who have completed training are board-eligible in pediatrics. The three-year fellowship program includes course work and clinical practice in growth and development, adaptation, injury prevention, disease prevention and health promotion. The program is also available to provide continuing education and technical assistance.

- The Department of Health, with the School of Public Health at the University at Albany, the New York State Community Health Partnership and the New York State Association of County Health Officials, sponsors monthly Third Thursday Breakfast Broadcasts (T2B2). T2B2 provides statewide continuing education opportunities covering a variety of public health issues. Local site coordinators in each county health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University at Albany's website: www.albany.edu/sph/coned/t2b2site.html. Continuing medical and nursing education credits are available.

- ***/2009/The Department of Health, under a community grant from the March of Dimes, collaborated with staff at the School of Public Health at the University at Albany and other partners to provide web-based training for oral health professionals, prenatal care providers and child health professionals on practice guidelines on oral health during pregnancy and early childhood. The training was part of the Women's Health Grand Round Series. Over 320 health professional attended the live broadcast and close to 1,600 individuals have visited the site to review the training program.//2009//***

- The Office of Children and Family Services also sponsors with partners such as DOH, the SUNY Distance Learning Project, and the New York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such as SIDS and Risk Reduction.

- /2008/Title V staff worked with the Weatherization Program at the Division of Housing and Community Renewal to distribute information about local weatherization contacts to MCH programs and contractors. For many families in the northeast, fuel prices are such that families suffering from fuel insecurity may need to choose between "heat or eat." //2008//

- DOH strives to maintain positive and collaborative relationships with several not-for-profit, voluntary groups who share concerns for the health and well-being of mothers, infants, children and women of childbearing age. The Department's Title V program has many active relationships/collaborations.

/2008/Please see pages 166-168 in the Needs Assessment section for a list of active collaborations.//2008//

F. Health Systems Capacity Indicators

Introduction

/2009/ Summary: //2009// Health System Capacity Indicators (HSCIs) are helpful in tracking trends in the population and measuring progress toward our health system goals. The HSCIs are also helpful in benchmarking with other states.

New York goes well beyond the Health System Capacity Indicators in its published Needs Assessment document each year. /2008/NYSDOH also publishes many of these data in more detail, with New York City vs. Rest of State data and with breakdowns by race/ethnicity, sex, age and other variables. All data are analyzed from different perspectives to determine whether the benefits of public health interventions are being realized by all segments of New York's population.//2008// ***/2009/ These key Health Systems Capacity Indicators show some minor***

changes from the last year's reported figures, some positive, some negative. //2009//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	72.7	67.3	57.9	59.9	59.9
Numerator	8833	8381	7236	7409	7409
Denominator	1215052	1246045	1249101	1236719	1236719
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2006 data are being used as a proxy for 2007.

Notes - 2005

Narrative:
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.***//2009//***

Notes - 2008
/2008/2005 data are being used as a proxy for 2006.//2008//

Narrative:
Rates went from 65.8 in 1998, to 81.5 in 1999, to 62.9 in 2000, to 66.6 in 2001, 65.4 in 2002, 72.7 in 2003 and 67.3 in 2004. /2008/Rates declined in 2005.//2008// /2009/ Although there was an increase in 2006, the increase was small, and the rate is still significantly below the rate in 2004. //2009// Rates continued to be higher in New York City, compared to the rest of the State. We are continuing to monitor these rates as we continue implementing the Statewide Asthma Plan.

/2008/ In 2006, New York State Department of Health published a Summary Report of New York data from the National Asthma Survey, which was widely distributed. The National Asthma Survey is a random digit dialing telephone survey that screened for presence of asthma in each household called. A maximum of one adult and one child who ever had asthma were randomly selected for a more detailed interview. Overall 31,090 individuals from 11,713 household were screened, with 1,970 detailed interviews completed (1,323 adults and 647 children). This survey provided a great deal of information on lifetime and current asthma. Below are some highlights:

- About 467,000 children, birth to age 17 or 10.6% of the NYS child population have been told by a health professional that they ever had asthma and about 368,000 or 8.4% had current diagnosed asthma.
- Current asthma prevalence varied by age groups. For children birth to age 4, the rate was 6.7%, for five- to nine-year-olds, the rate was 9.4%, for 10- to 14-year-olds, the rate was 8.8%, and for 15- to 17-year-olds, the rate was 8.3%. For adults, the 18- to 24-year-old age group

had the highest current asthma prevalence at 9.8%. The 65+ age group had the lowest rate at 6.0%.

- Current asthma prevalence is significantly higher in male children (9.8%) compared to female children (6.8%), but prevalence in adult females (9.0%) is higher than in adult males (6.0%).
- Current asthma prevalence also varied by race. Black children had the highest prevalence at 10.0%, compared to White (7.2%) and Asian children (4.3%). Black adults also had higher rates (8.3%) than White (6/6%) and Asian (1.8%) adults.
- Ethnicity is also a factor. Hispanics had higher current asthma prevalence than non-Hispanic children (10.9% vs. 7.4%) and adults (9.0% vs. 6.3%).
- There were also regional variations, with New York City children having higher prevalence than children in the rest of the State (9.7% vs 7.4%), and New York City adults having lower rates than adults in the rest of the state (7.1% vs. 8.0%).
- Children and adults living below the Federal Poverty Level (FPL) had higher current asthma prevalence than those above the FPL. For children the prevalence rates were 10.1% for those below FPL vs. 8.7% for those above; for adults rates were 9.2% for those below FPL vs. 7.2% for those above.
- Current asthma prevalence increased as body mass index (BMI) increased. Underweight children had prevalence lowest rates at 7.4% vs. overweight children who had the highest prevalence rates at 10.1%. Among adult, the obese group also had the highest prevalence rates at 12.3%.

Asthma coalitions are using regional approaches to track these and other data, and to ensure that New Yorkers with asthma have asthma management plans and receive high-quality care. Please see additional details under Priorities, Performance and Program Activities.

Columbia University, in collaboration with the Harlem Family Asthma Center at Harlem Hospital, is providing a comprehensive, multi-disciplinary family program to children with severe asthma. The program will improve asthma management practices for primary care practitioners who care for children with mild to moderate asthma. Among 140 children, hospital admissions decreased 22% to 14% of clients. The number of clients with two or more emergency department visits decreased from 36% to 10%. The percentage of children with ten or more days of school missed went from 24% to 0%. Use of preventive asthma medications increased from 76% to 95%. Each client having an asthma action plan increased from 38% to 90%.

"Use of Appropriate Asthma Medications" is a performance measure in QARR and is reported annually in the Managed Care Plan Performance document. Statewide we are at 94% for commercial and Child Health Plus plan performance and 90% for Medicaid plan performance. //2008// ***/2009/ For the most recent data year available, QARR data shows that 95% of commercial, 94% of Child Health Plus and 92% of Medicaid plans achieved this goal.//2009//***

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	74.7	76.5	76.9	72.7	72.7
Numerator	103303	110535	111874	108995	108995
Denominator	138216	144460	145432	149958	149958
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2006 data are being used as a proxy for 2007.

Narrative:
/2009/ Notes -- 2009
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//

Notes - 2008
/2008/2005 data are being used as a proxy for 2006. //2008//

Notes - 2003
Comparable Data not available for 1999 - 2001

Narrative:
Idiosyncrasies in data sources and analysis make those data hard to interpret. It appears we are on an upward trend, but have just /2008/four//2008// ***/2009/ five //2009//*** years of data consistency. ***/2009/ The 2006 numbers, however, represent a slight decrease. //2009//***

Title V staff continue to monitor access to programs and services on a local level and work with the Office of Medicaid Management to identify and solve access issues. /2008/ The related QARR measure is "Five or More Well Child and Preventive Care Visits in the First 15 Months of Life." While rates are 90% for the commercial managed care population, they are 65% for Medicaid plans and 85% for Child Health Plus plans. //2008// ***/2009/ In the most recent data year available (2006), new data was reported only for the Medicaid managed care plans, whose rate increased to 70%.//2009//***

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	79	79	84	84	84
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2006 data are being used as a proxy for 2007.
Data are for the percent of children aged 15 months who recieved 5+ well child visits

Narrative:
/2009/ Notes -- 2009
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//

Notes - 2008
/2008/2005 data are being used as a proxy for 2006. //2008//

Notes - 2003
We do not have reliable data for Child Health Plus enrollees under age one. As a proxy, the percentage of children under age 15 months who have received a well child or preventive health visit is used.

Starting in 1999 a new data source became available. Using this source the percentage is weighted by plan enrollment. Since the rate is a weighted rate the numerator and denominator are not available or relevant.

Narrative:
New York uses QARR data from the Office of Managed Care to generate these data, and as a result, have slightly different categories of data. What is available is "Five or More Well Child and Preventive Care Visits in the First Fifteen Months of Life." These data remain about stable or increasing: 62.0% in 2001, 67.0% in 2002, 79% in 2003 and 2004, /2008/ and 84% in 2005//2008//. ***/2009/ The increase to 84% has been stable for 2006, and if maintained, represents an overall increase of more than 35 percent since 2001.//2009//***

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	63.1	66.4	66.5	65.9	65.9
Numerator	137129	132863	130854	131416	131416
Denominator	217201	200115	196825	199342	199342
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2006 data are being used as a proxy for 2007.

Narrative:

/2009/ Notes -- 2009
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//

Notes - 2008
/2008/2005 data are being used as a proxy for 2006. //2008//

Narrative:
These data have been trending toward improvement. There was a one-year of decrease from 2000 to 2001, then rates were relatively unchanged from 2001 to 2002, at 63.5% and 63.6%, respectively. The rates showed improvement from 63.1% in 2003 to 66.4 % in 2004. /2008/ At 66.5%, the rate is level with 2004 rates.//2008// ***/2009/ A slight decrease, to 65.9% in 2006, was observed.//2009//***

There are racial and geographic disparities in these rates. In New York City in 2004, the Kotelchuk Index was 59.9, while the rest of the state achieved 72.2 on the index. For White New Yorkers, the index was 70.2. for African Americans it was 53.0, and for Hispanic women it was 57.8. /2008/ The 2005 Kotelchuk indices for New York women ages 15 to 44 were higher among women residing in Rest of State (73.2) as compared to women residing in New York City (59.5) and higher for White women (70.7) as compared to Black (53.6) and Hispanic women (57.9). The 2005 rates were similar to rates in 2004, but much improved over rates reported in 1996. These data are also tracked in QARR.//2008

The Prenatal Care Assistance Program sets clinical standards for content of prenatal care, which are codified in Part 85.40 of New York State Public Health Law. Programs are reviewed for their compliance with these standards. /2008/ These same standards are applied to the MOMS (Medicaid Obstetrical Maternity Services) Program, as well. These regulations serve as the standard of care. //2008// ***/2009/ The prenatal media campaign encourages women to access services through the Prenatal Care Assistance Program, and outreach efforts conducted through the Community Health Worker program, and the soon-to-be-implemented Universal Prenatal and Postpartum Home Visiting Program, represent key efforts to encourage women to seek early and continuous prenatal care. In addition, the 2008-09 Executive Budget includes initiatives to improve birth outcomes for the close to 50 percent of births in the state that are paid for by Medicaid, because women insured by Medicaid have higher rates of infants with complicated and costly neonatal intensive care. Over a period of 4 years, reimbursement methodology will be reallocated primarily for investments in ambulatory care and preventive care for Medicaid patients. It is anticipated that this process will be fully implemented in 2011-2012. As a first step the Budget proposes to invest in a new standardized system of early identification of clinical and psychosocial risks for poor birth outcomes. The Department's leadership of the Medicaid and Public Health offices will undertake a comprehensive review, in consultation with all stakeholders, of Medicaid's prenatal care standards and reimbursement methodologies to ensure that New York State is buying the highest quality care, in the right setting, at the right price for the pregnant women we cover. Additionally, nurse practitioners who previously could only bill Medicaid for primary care services will now be able to bill in all specialties, including mental health; and, licensed clinical social workers will be reimbursed for services for children, adolescents and pregnant women.***

The transfer of the Adolescent Pregnancy and Parenting Services (APPS) program from the Office of Children and Family Services will allow for greater coordination of services for pregnant adolescents through 21 years of age. Twenty-six programs are funded through community based organizations across the state providing the following services: counseling; basic needs; academic education; health services; employment services; recreational services; parent education; housing services; child care; and, services for infants and children.//2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	91.0	93.4	94.6	94.4	94.4
Numerator	1834078	1974655	1966625	1909170	1909170
Denominator	2015608	2113319	2079460	2021928	2021928
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2006 data are being used as a proxy for 2007. The denominator represents all children currently enrolled in Medicaid.

Narrative:
/2009/ Notes -- 2009
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//

Notes - 2008
/2008/2005 data are being used as a proxy for 2006.//2008//

Narrative:
/2008/These data are difficult to interpret because it is unclear what the purpose of the visit was.//2008// ***/2009/ However, this indicator demonstrated an increasing trend until 2005, and relative stability in 2006.//2009//***

/2008/In 2005, 43.1% of all obstetrical deliveries were either paid by Medicaid or self-pay. QARR tracks plan performance on a variety of primary and preventive health care measures, including immunization status, lead testing, use of appropriate asthma medications, annual dental visits, and appropriate treatment for Upper Respiratory Infection. Also tracked are: appropriate testing for pharyngitis, number of well child visits, follow-up on medications for ADHD, and adolescent preventive measures, including BMI screening, nutrition and exercise assessment, sexual activity counseling and education, depression screening, and tobacco and substance use screening and counseling. //2008//

All Title V programs have a component that assures that potentially-eligible families are referred to public insurance programs. /2008/Title V programs have linkages to facilitated enrollment programs and the local departments of social services, where eligibility determinations are often performed.//2008//

Local CSHCN Program staff inquire as to the insurance status of each child who is referred to the CSHCN Program. Staff link families to public insurance programs such as Medicaid, Child Health Plus and Family Health Plus and gap-filling programs such as the Physically Handicapped

Children's Program. In 2005, 6% of CSHCN were reported as without health insurance. There were 82 CSHCN referred and enrolled in Medicaid, 33 CSHCN referred and enrolled in CHP-B, and 13 CSHCN referred and enrolled in SSI. There are 145 referrals to insurance pending results at this point of data collection.

/2009/Obtaining information about health insurance status, including Medicaid coverage, is a required part of the initial enrollment process for students who enroll in school-based health centers (SBHC). SBHC staff request parents/guardians to include this information on the background and consent forms required for students to obtain services through the SBHC. If the parent/guardian reports no coverage, staff of the SBHC and/or the sponsoring health care provider, works with them through a facilitated enrollment process, to identify any health care coverage for which they are eligible for such as Medicaid, Child Health Plus or Family Health Plus.

The Department of Health, under a community grant from the March of Dimes, collaborated with staff at the School of Public Health at the University at Albany and other partners to provide web-based training for oral health professionals, prenatal care providers and child health professionals on practice guidelines on oral health during pregnancy and early childhood in an effort to encourage provision of services to these populations. The training was part of the Women's Grand Round Series. Over 320 health professional attended the live broadcast and close to 1,600 individuals have visited the site to review the training program.//2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	35.2	36.3	38.9	44.3	44.3
Numerator	134265	140454	144365	159486	159486
Denominator	381935	386892	370657	360268	360268
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2006 data are being used as a proxy for 2007. The denominator represents all children age 6-9 enrolled in Medicaid in 2007.

Narrative:
/2009/ Notes -- 2009
2006 data are being used as a proxy for 2007, and 2006 data have been updated and finalized.//2009//

Notes - 2008
/2008/2005 data are being used as a proxy for 2006.//2008//

Narrative:

In 2002, the percentage was 35.8%; in 2003 the percentage was 35.2%: in 2004 the percentage was 36.3%/2008/ and in 2005, 38.9%//2008//. It appears that percentages are stable /2008/ with a slight increase in 2005.//2008//. ***/2009/ Adjustments to preliminary data show that this indicator has been relatively stable in increasing over the past 5 years, with a significant jump in 2006.//2009//*** We believe this***/2009/ (the generally low overall number) //2009//*** is due to the limited number of dentists willing to take Medicaid. (The number of clients across all age groups who receive MA-financed dental services is low, despite fees having been raised.) ***/2009/ Statewide, approximately 50% of all licensed dentists are enrolled as approved Medicaid providers, but only half of these actually provide services to Medicaid beneficiaries. //2009//*** These issues are addressed in our statewide Oral Health Plan. /2008/The New York State Oral Health Coalition has a special Access to Care Sub-Committee that meets regularly to implement those sections of the plan that relate to access to oral health care.//2008// ***/2009/Data on Medicaid claims for dental services during 2006 were available for 6-7 year olds and 8-11 year olds. Based on an analysis of unduplicated beneficiaries, 42.0% of 6-7 year olds and 42.5% of 8-11 year olds had at least one dental visit during 2006. //2009//***

/2008/ The Bureau of Dental Health recently published information on a successful strategy that was tested in New York called Dental Case Management. This is a promising strategy for improving access to dental care statewide. The Bureau is currently seeking resources to expand the use of this model in more communities. In addition, 32 community-based sites were recently awarded Preventive Oral Health Services Grants. These sites will undertake a variety of activities that will contribute to more children having a dental home, from case management, to sealant programs, to coalition building, to comprehensive dental treatment programs.//2008// ***/2009/ There are currently 31 contracts for Preventive Oral Health Services in place, as one awardee declined a contract.//2009//***

/2008/ In addition, the Bureau of Dental Health recently funded an additional 32 Preventive Dentistry applicants across the state. These projects are entirely focused on the maternal and child health populations. The majority of the projects are to provide either dental sealants or fluoride varnish. Several of the projects focus on pregnant women, with the goal of positively impacting knowledge, attitudes and behaviors of pregnant women, who will become better advocates for and consumers of oral health care, not only for themselves, but also for their young children.//2008// ***/2009/ In addition, these projects undertake a variety of activities that will contribute to more children having a dental home, from case management, to sealant programs, to coalition building, to comprehensive dental treatment programs.***

The Bureau of Dental Health is in year one of a four year HRSA grant targeting oral health services to the maternal child health population. Grant activities focus on increasing access to and utilization of dental services by children covered under EPSDT and in increasing the provision of treatment services to 6-9 year old children identified through the school-based dental program with active decay.//2009//

/2008/The Bureau of Dental Health is working with other CDC chronic disease grant programs within the department on issues where there is a similar target audience or message. One area that is promising for joint intervention is in the area of tobacco use prevention. Dental hygienists are giving out anti-tobacco messages and referring clients to the smoking cessation hotline. It is anticipated that similar messages could be crafted for younger populations. //2008//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1	1	1	1	1
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
All SSI beneficiaries receive Medicaid which is a more generous package than that available under the Physically Handicapped Children's Program.

Notes - 2006
All SSI beneficiaries receive Medicaid which is a more generous package than that available under the Physically Handicapped Children's Program.

Notes - 2005
All SSI beneficiaries receive Medicaid, which is a more generous package than that available under the Physcally Handicapped Children's program.

Narrative:
Notes - 2008
All SSI beneficiaries receive Medicaid, which is a more generous package than that available under the Physically Handicapped Children's program/Children with Special Health Care Needs Program. ***/2009/ In 2007, 1.24% of children enrolled in the CSHCN Program had SSI. //2009//***

Narrative:
This indicator is not particularly applicable to New York, since all SSI recipients automatically have Medicaid, which is more generous than our Physically Handicapped Children's Program/Children with Special Health Care Needs Program.

The local Children with Special Health Care Needs Program provides information and referral to families in need of services, including referrals and assistance with enrollment in Medicaid, Child Health Plus, and ***/2009/ Supplemental Security Income and enabling services.//2009//***

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	8.6	8.2	8.3

Notes - 2009
The "All" rate includes births with unknown payment source.

Narrative:
In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to low birth weight rates, infant mortality, rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payment for their care, but more likely attributable to a confluence of life factors.

/2008/ The presence of PCAP and MOMS Programs across the state increases access to high-quality prenatal care for high-risk, hard-to-reach women. PCAP/MOMS engages strategies to enroll and sustain enrollment of women in prenatal care. Standardized risk assessment helps to identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to regional perinatal centers and supportive health and social services.//2008// ***/2009/ In addition, a prenatal outreach media campaign was conducted to encourage pregnant women to seek prenatal care early, by calling the Growing Up Healthy Hotline, while the Community Health Worker Program provided individual outreach to high risk pregnant women. The Universal Prenatal and Postpartum Home Visiting Program was also designed in 2007, to be implemented in 2008, to provide universal screening to pregnant and postpartum women to connect them with needed services. A re-design of the Medicaid payment system, inclusive of prenatal care, is also being undertaken to ensure that the current high standard of care for Medicaid-enrolled women is both universal and of meets the current standard of practice.***

The transfer of the Adolescent Pregnancy Prevention and Services program to the Department of Health will allow the Department to better track the pregnancy outcomes of high risk pregnant adolescents. One of the five statewide performance targets for the projects is the expectation that at least 90% of those babies born by teen parents in their program will have a birth weight above 88 ounces.//2009//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	payment source from birth certificate	6.2	4.4	5.6

Notes - 2009
The Medicaid and non-Medicaid infant death rates are based on deaths of infants residing in NYS excluding NYC. THe 2006 birth-death match file from NYC has not yet been provided by NYC. The All rate is a statewide rate for all births including births with unknown payment source.

Narrative:
/2009/*The Medicaid and Non-Medicaid infant death rates are based on deaths of infants residing in NYS excluding NYC. The 2006 birth-death match file from NYC has not yet been provided by NYC.//2009//

Notes - 2008
These data are for Medicaid and non-Medicaid infant mortality rates are for residents of New York State living in areas outside New York City. Information on method of payment for delivery was

not available for 2005 NYC births.

/2008/The 2005 Infant Death File, used for matching with Birth Records and payment source of delivery was not forwarded by New York City Department of Health and Mental Health to New York State DOH in time for inclusion in this report. Data will be updated as it becomes available. //2008//

Narrative:
Infant mortality for all births to NYS residents living outside of NYC was 6.0 per 1,000 births in 2004/2008/, while the rate was 5.8 per 1,000 births in 2005. //2008// ***/2009/ In 2006, the infant mortality rate for NYS babies, exclusive of NYC, was 6.2 percent for Medicaid clients, and 29% lower for non-Medicaid babies, at 4.4%. //2009//***

In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to low birth weight rates, infant mortality, rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payment for their care, but more likely attributable to a confluence of life factors.

/2008/ The presence of PCAP and MOMS Programs across the state increases access to high-quality prenatal care for high-risk, hard-to-reach women. PCAP/MOMS engages strategies to enroll and sustain enrollment of women in prenatal care. Standardized risk assessment helps to identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to regional perinatal centers and supportive health and social services.//2008// ***/2009/ As previously stated, the Growing Up Healthy Hotline, the Community Health Worker Program and the Universal Prenatal and Postpartum Home Visiting Programs were designed to address the issue of ensuring that all pregnant and postpartum women are provided with access to needed services. Though the latter program is in the earliest stages of implementation, it is expected to add an additional element to the state's armamentarium with respect to improving birth outcomes. A further element, previously described, is the Medicaid payment reform effort, which will use the payment structure to encourage delivery of prenatal care according to the highest professional standards. //2009//***

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	62.9	83.7	74.6

Notes - 2009
The All rate incudes births with unknown payment source.

Narrative:

Narrative:
In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to low birth weight rates, infant mortality, rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payment for their care, but more likely attributable to a confluence of life factors.

/2008/ The presence of PCAP and MOMS Programs across the state increases access to high-quality prenatal care for high-risk, hard-to-reach women. PCAP/MOMS engages strategies to enroll and sustain enrollment of women in prenatal care. Standardized risk assessment helps to identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to regional perinatal centers and supportive health and social services.//2008// ***/2009/ Outreach and case finding components of the state's prenatal care strategy also include the Community Health Worker Program, which is targeted to very high risk pregnant women, the Growing Up Healthy Hotline, which links women to a comprehensive array of needed services, and the Universal Prenatal and Postpartum Home Visiting Program, which is still in the earliest implementation stages, but is designed to fill a gap in the state's current array of programs. In addition, as previously described, a re-design of the state's Medicaid reimbursement system is currently in the planning stages, and care is being taken to ensure that the system will promote only the highest standards of evidence-based care, targeted to the risk-based needs of each woman. //2009//***

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	53.9	73.8	65.9

Notes - 2009
The All rate includes births with unknown payment source.

Narrative:
Narrative:
In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy higher standards of living. Medicaid populations generally fair less favorably than privately insured populations with regard to low birth weight rates, infant mortality, rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payment for their care, but more likely attributable to a confluence of life factors.

/2008/ The presence of PCAP and MOMS Programs across the state increases access to high-quality prenatal care for high-risk, hard-to-reach women. PCAP/MOMS engages strategies to

enroll and sustain enrollment of women in prenatal care. Standardized risk assessment helps to identify women at risk for poor pregnancy outcome and provides additional services to address those needs. Women at highest risk are referred to regional perinatal centers and supportive health and social services.//2008// ***/2009/ Integral to the state's outreach and referral efforts are the Community Health Worker Program, targeted to very high risk women, the Growing Up Healthy Hotline, which provides referrals on a whole range of services to all women statewide, and the Universal Prenatal and Postpartum Home Visiting Program, currently in the planning stages. In addition, reform of the state's Medicaid reimbursement system to an APG-based structure is currently being developed, and is being designed in a manner that should aide in improvements in the delivery of prenatal care in New York State.***

Pregnant school-based health center enrollees are entered into prenatal care immediately. School-based health center staff may provide services directly, coordinate services with another provider or refer pregnant students for appropriate prenatal care. School-based health center staff follow-up to ensure that there is continuity of care. Where indicated, referrals are made for additional supportive health and social services.//2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	250

Narrative:
Narrative:
Medicaid: Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level, are eligible for Medicaid. Women are eligible for family planning based solely on the woman's income being below 200% of the Federal Poverty Level, planning based solely on the woman's income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. If women are on New York State Medicaid at the time of pregnancy, then lose their eligibility, they are eligible for 24 months of continuous family planning coverage following their pregnancy.

Children one through five are eligible for Medicaid at 133% of FPL. Children ages six to nineteen are eligible at 100% of the FPL.

Child Health Plus (New York's SCHIP): Children, ages one month to age 19 years, with family incomes at or below 250% of the FPL are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 250% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services.

Family Health Plus is available at two levels. Adults with children under the age of 21, whose gross family annual income is up to 150% of the Federal Poverty Level, or $30,000 for a family of four, are eligible. Single adults, with gross family incomes up to 100% of the Federal Poverty

level or $9,800 per individual, are also eligible.

/2008/*These eligibility levels are scheduled to change very soon. New York is working toward making Child Health Plus available up to 400% of the Federal Poverty Level. The New York State Department of Health website is the best source of current eligibility information. Use www.health.state.ny.us or www.nyhealth.gov //2008//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	 250

Narrative:
Notes - 2007
This section of the form is labeled wrong. It should read "Children under SCHIP" and not "Medicaid Children."

Narrative:
Medicaid: Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level, are eligible for Medicaid. Women are eligible for family planning based solely on the woman's income being below 200% of the Federal Poverty Level, planning based solely on the woman's income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. If women are on New York State Medicaid at the time of pregnancy, then lose their eligibility, they are eligible for 24 months of continuous family planning coverage following their pregnancy.

Children one through five are eligible for Medicaid at 133% of FPL. Children ages six to nineteen are eligible at 100% of the FPL.

Child Health Plus (New York's SCHIP): Children, ages one month to age 19 years, with family incomes at or below 250% of the FPL. are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 250% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services.

Family Health Plus is available at two levels. Adults with children under the age of 21, whose

gross family annual income is up to 150% of the Federal Poverty Level, or $30,000 for a family of four, are eligible. Single adults, with gross family income is up to 100% of the Federal Poverty level or $9,800 per individual, are also eligible.

/2008/ *These eligibility levels are scheduled to change very soon. New York is working toward making Child Health Plus available up to 400% of the Federal Poverty Level. The New York State Department of Health website is the best source of current eligibility information. Use www.health.state.ny.us or www.nyhealth.gov //2008//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2007	200

Narrative:
Notes - 2007
Pregnant women are eligible for Medicaid and Child Health Plus up to 200% of poverty.

Narrative:
Medicaid: Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Level (up from 185%), are eligible for Medicaid. Women are eligible for family planning based solely on the woman's income being below 200% of the Federal Poverty Level, planning based solely on the woman's income being below 200% of the Federal Poverty Level, regardless of previous Medicaid eligibility or pregnancy. If women are on New York State Medicaid at the time of pregnancy, then lose their eligibility, they are eligible for 24 months of continuous family planning coverage following their pregnancy.

Children one through five are eligible for Medicaid at 133% of FPL. Children ages six to nineteen are eligible at 100% of the FPL.

Children, ages one month to age 19 years, with family incomes at or below 250% of the FPL. are eligible for subsidized health insurance coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for families between 160 and 222% is $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 222 and 250% FPL, the contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 250% of the FPL, Child Health Plus is available at full premium. There are no co-payments for services.

Family Health Plus is available at two levels. Adults with children under the age of 21, whose gross family annual income is up to 150% of the Federal Poverty Level, or $30,000 for a family of four, are eligible. Single adults, with gross family income is up to 100% of the Federal Poverty level or $9,800 per individual, are also eligible.

/2008/These eligibility levels are scheduled to change very soon. New York is working toward

making Child Health Plus available up to 400% of the Federal Poverty Level. //2008//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:
Notes -- 2008 --
/2008/WIC matches are on a study basis only. //2008//

Narrative:
MCH data is placed on the NYSDOH's public website, HIN and on the HPN (NYSDOH's provider health networks). Regional Perinatal Centers and Local Health Departments also have access. The Title V application is available on the public website, as well.

/2008/ In addition to data matching and survey activities, several NYSDOH initiatives currently have data capacity expansion projects either planned or in process.

- The Early Childhood Comprehensive Systems initiative is working on ways to share

information between state agencies working on early childhood issues.

- The Dental Public Health Residency Program has contributed to the development of reports on the impact of oral diseases that is widely shared, both within the department and outside through the New York State Oral Health Coalition.
- The Bureau of Dental Health partners with PRAMS and produced reports that were the basis of oral health guidelines for the care of pregnant women and young children. The Bureau is also working on a report on the current status of fluoride varnish application in the state.
- The Bureau of Dental Health and the Dental Public Health Residents are currently conducting a surveillance study of Early Head Start/Head Start children for oral disease. ***/2009/ This study has recently been completed.***
- ***The Bureau of Dental Health works closely with Medicaid on producing county and age-specific data on the use of dental services by the maternal child health population and the actual types of services received. The data are being used to identify areas in the state with the greatest need for services as well as to formulate policy recommendations for changes in Medicaid procedures in order to increase access and utilization of dental services to best address unmet needs. //2009//***
- The Bureau is working with the Integrated Child Health Information System (ICHIS) to investigate the addition of oral health and BMI data to the existing ICHIS records.
- The Children with Special Health Care Needs Program data upgrade is in cue for data cleansing and pilot testing. The upgraded application will improve the quality of the data reported to the NYSDOH and provide local program with the capability to run reports on their own data. The generation of these reports is a new feature that will allow use of the data to make local service systems improvements.
- The Comprehensive School Health Initiative works the State Education Department and facilitates the widespread dissemination of Youth Risk Behavior Survey (YRBS) data. //2008//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Youth Tobacco Survey	3	No

Notes - 2009

Narrative:

Narrative:

New York participates /2008/ in the Youth Risk Behavior Survey (YRBS) through the State Education Department (NYSED). Adolescent smoking rates are available /2008/to the New York State Department of Heath through both the YRBS and through the Youth Tobacco Survey. The Division of Chronic Disease Prevention and Adult Health employs an epidemiologist for the tobacco program who works with both adult and child smoking data. /2008/ These data analyses are readily accessible to the Title V programs and the Public Health Information Group. NYSED publishes the survey data on their website. //2008//

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section profiles New York's maternal and child health priorities, selected performance measures, and program activities and discusses the extent to which National and State objectives were met in this program year.

As previously described, New York has undergone extensive priority-setting processes. Throughout, participants decline to rank priorities, preferring that each of these "opportunities for improvement" be considered of equal importance. Following the last five-year assessment cycle required by Title V, and in consideration of past progress, several performance targets were re-adjusted. The ten priorities that follow, and the specific performance measures related to each, stem specifically from areas of unmet need in the State.

New York Title V is using an Oracle-based system for gathering and managing program information that delineates goals, objectives, sources of funds, staffing and performance measures for the maternal and child health-related programs. These data are gathered from program managers in all of the MCH-related programs, whether or not the programs are block grant funded. ***/2009/ Due to staffing and other changes, the Oracle-based system was supplanted by a more streamlined information gathering approach, requesting programs to review the narrative for the application and update their programmatic information more directly. This provision of a context for their updates resulted in closer contact of program managers with the content of the application, and allowed them a better overview of how their program contributed to the overall MCH picture in NYS. Fiscal information requested was pared down to essentials in order to improve the quality of the information collected. Since the methodology for collection of fiscal information was completely changed, continuity of data from the 2008 to the 2009 application may be impacted, although any changes should result in improvements in the quality of the fiscal information.//2009//***

Most often, programs that address maternal and child health issues initiate services and interventions on a variety of levels. For example, in addressing access to care, we are improving the insurance and charity care infrastructure, targeting population-based messages, enabling clients to access and sustain their relationship to a medical home, and work to remove barriers to accessing high-quality direct medical services. Thus, each of the four levels of the MCH pyramid may be relevant to a particular need.

A brief summary of New York's accomplishments through use of Title V and other funds appears in Section B. New York's progress on Federal and State Performance and Outcome Measures are tracked on Forms 11 and 12.

B. State Priorities

After the last full Needs Assessment (which is done annually in New York), priority setting was conducted as a melding process, combining:

- The use of the many and various data sets available to the Department;
- The use of program data and provider input to identify trends and issues;
- Infrastructure evaluation;
- The results of multiple cross-departmental and public participative processes;
- The input of the public and the Maternal and Child Health Services Advisory Council to assist in interpreting these data and identifying important trends, gaps in services or barriers to care; and
- The input of key staff within the Department.

The process remains unchanged since the last application. Collaborations and partnerships that contribute to the needs assessment process /2008/ continue to expand and grow.//2008//

As a result of the needs assessment process and subsequent discussion, the following ten priorities were identified:

- To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal care and primary and preventative care, which includes attention to mental health issues and which serves those with special health care needs;
- To improve oral health, particularly for pregnant women, mothers and children, and among those with low income;
- To prevent and reduce the incidence of overweight for infants, children and adolescents;
- To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
- To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
- To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
- To reduce unintended and adolescent pregnancies;
- To ensure the availability of comprehensive genetics services statewide, including follow-up on positive newborn screening tests, specialty services and genetics counseling for affected families;
- To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicides in 15- to 19-year-olds; and
- To improve parent and consumer participation in the Children with Special Health Care Needs Program, as evidenced by parent scores.

The justification for their selection as priorities may be found in Section II. B. 1. and a description of our planning/targeting framework may be found in Section II. A. of the Needs Assessment. This same section also contains a table that summarizes the relationship between New York's priority needs and the measurement of their progress through Federal and State Performance and Outcome Measures.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	254018	250209	246243	252014	255275
Denominator	254018	250259	246243	252014	255275
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

• 255,275 infants were screened for genetic disorders in 2007 by NYSDOH's Wadsworth Center Newborn Screening Program.
• 100% of newborns in NYS are tested for over 40 congenital conditions, including:
• Congenital adrenal hyperplasia (CAH)
• Congenital hypothyroidism (CH)
• Sickle cell disease
• exposure to HIV-1
• Homocystinuria
• Hypermethioninemia
• Maple syrup urine disease
• Phenylketonuria
• Tyrosinemia
• Carnitine-acylcarnitine translocase deficiency (
• Carnitine palmitoyltransferase deficiency
• Carnitine uptake defect
• 2,4-Dienoyl-CoA reductase deficiency
• Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency
• Medium-chain acyl-CoA dehydrogenase deficiency
• Medium-chain ketoacyl-CoA thiolase deficiency (
• Medium/short-chain hydroxyacyl-CoA dehydrogenase deficiency
• Mitochondrial trifunctional protein deficiency
• Multiple acyl-CoA dehydrogenase deficiency
• Short-chain acyl-CoA dehydrogenase deficiency
• Very long-chain acyl-CoA dehydrogenase deficiency
• Glutaric acidemia
• 3-Hydroxy-3-methylglutaryl-CoA lyase deficiency
• Isobutyryl-CoA dehydrogenase deficiency
• Isovaleric acidemia
• Malonic acidemia
• 2-Methylbutyryl-CoA dehydrogenase deficiency
• 3-Methylcrotonyl-CoA carboxylase deficiency
• 3-Methylglutaconic acidemia
• 2-Methyl 3-hydroxybutyryl-CoA dehydrogenase deficiency
• Methylmalonic acidemia
• Mitochondrial acetoacetyl-CoA thiolase deficiency
• Multiple carboxylase deficiency
• Propionic acidemia
• Argininemia
• Argininosuccinic acidemia
• Citrullinemia
• Hyperammonemia/hyperornithinemia/homocitrullinemia
• Biotinidase deficiency
• Cystic Fibrosis
• Galactosemia
• Krabbe Disease
• Of children screened in 2007 there were 18 confirmed amino acid disorders including PKU; 12 confirmed cases of congenital adrenal hyperplasia; 200 confirmed cases of congenital hypothyroidism; 37 confirmed fatty acid disorders including MCAD; 244 hemoglobinopathies; 51 confirmed organic acid disorders including 3-MCC; 5 cases of biotinidase deficiency; 40 cases of cystic fibrosis, 5 cases of galactosemia and 4 cases of Krabbe disease.
• (See Form 6.) Expanded testing began in November 2004.

• The Newborn Screening Program and the Children with Special Health Care Needs Program implemented standards for new types of Specialty Centers.
• Prenatal Genetics Services were provided to 20,709 pregnant women in 2007.
• Another 30,143 individuals received Clinical Genetics Services through genetics services grantees.
• Wadsworth Laboratories continued to provide certification of clinical and environmental laboratories serving NYS residents.

Table 4a, National Performance Measures Summary Sheet

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 255,275 infants were screened for genetic disorders in 2007 by NYSDOH's Wadsworth Laboratories Newborn Screening Program. 100% of newborns in NYS are tested for over 40 congenital conditions.			X	X
2. Of children screened in 2007 there were 18 confirmed amino acid disorders including PKU; 12 confirmed cases of congenital adrenal hyperplasia; 200 confirmed cases of congenital hypothyroidism; 37 confirmed fatty acid disorders including MCAD; 244 hem		X	X	X
3. The Newborn Screening Program and the Children with Special Health Care Needs Program implemented and continues to monitor standards for Endocrine, Cystic Fibrosis and Inherited Metabolic Diseases Specialty Centers.				X
4. Prenatal Genetics Services were provided to 20,709 pregnant women in 2007.	X	X	X	X
5. Another 30,143 individuals received Clinical Genetics Services through genetics services grantees.	X	X	X	X
6. Comprehensive Prenatal/Perinatal Services Networks promote newborn screening and appropriate follow-up through newsletters and provider meetings.				X
7. NYMAC has formed two workgroups specifically charged to educate the professional and lay public about genetics and newborn screening. They are developing the means to distribute new and existing materials.			X	X
8. NY began screening for Krabbe Disease in August 06.	X	X	X	X
9. Through the NYS Newborn Screening website and the NYMAC website, http://www.wadsworth.org/newborn/nymac/index.html, individuals concerned with genetics services or specialty care are able to access educational resources or identify clinical services	X	X	X	X
10.				

b. Current Activities
• Wadsworth Center continues to screen 100% of the state's newborns for the conditions listed in the attachment. 98% of presumptive positive screens are followed to confirmation.
• Title V continues to monitor follow-up on active cases to ensure that infants with positive results receive appropriate follow-up.
• Local health units continue to use Article 6 State Aid reimbursement to pay for follow-up

visits by public health nurses or bill insurance companies for these services.

- Clinical genetic services, including follow-up genetic counseling for families of children with inborn metabolic errors, are available through the Genetics Program. The Wadsworth Center administers 25 contracts that ensure access to services regardless of the family's insurance or financial status.
- Comprehensive Prenatal/Perinatal Service Networks promote newborn screening and appropriate follow-up through newsletters and provider meetings.
- NYMAC has formed two work groups specifically charged to educate the professional and lay public about genetics and newborn screening, and maintains an extensive mailing list of all persons involved in or interested in genetics, newborn screening and specialty care.
- About 105,006 children were tested for Krabbe disease from August to December 2006; all newborns were screened for Krabbe in 2007.
- Hemoglobinopathy criteria for specialty centers were jointly reviewed by the CSHCN and Newborn Screening staff and the Office of the Medical Director.

c. Plan for the Coming Year

- The Newborn Screening Program will continue to screen all newborn blood spots. Courier pick-up will continue with delivery at the Laboratory expanding to include Saturday.
- The CSHCN and the Genetic Screening Programs will continue to monitor implementation and ensure appropriate follow-up services.
- NYSDOH Title V staff will remain involved in NYMAC activities.
- NYMAC and the Genetic Service Program will investigate ways to maximize resources/reimbursement for genetic services providers.
- Wadsworth Center will continue to assure that clinical public health laboratories are available to the residents of New York State, including but not limited to: an anatomic pathology laboratory; a cytogenetic laboratory for diagnosis of prenatal and clinical abnormalities; and a laboratory for identification of reproductive and metabolic disorders.
- Wadsworth Center will continue to operate a state-of-the-art clinical and environmental laboratory evaluation program to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests.
- There are no plans for further changes at this time. NYS will continue to implement the expanded test panel and follow-up on all positive findings.
- The CSHCN and Newborn Screening Programs will review the draft Hemoglobinopathy specialty center criteria with an expert physician panel. Based upon the expert panel review, criteria will be finalized and Article 28 hospitals will be invited to apply for specialty center designation.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	65	70	62	64	66
Annual Indicator	60.3	60.3	60.3	60.3	59
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	66	67	67	68	68

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

- The CSHCN Program continued to employ a Family Specialist, the parent of a child with special health care needs.
- The CSHCN Program continued to engage our cadre of Family Champions by seeking their perspectives on the development, implementation and evaluation of resources and tools for use by CSHCN families and the MCH programs that serve these families. The cadre of family representatives was expanded to include the four family representatives to the Child Development Learning Collaborative. Quarterly conference calls are held.
- The CSHCN Program continues to broaden parent input in policy development, improving access to health and related services for CSHCN, identifying and referring CSHCN to appropriate services, and collecting information to identify gaps and barriers in order to improve the system of care for CSHCN. One example is our Family Specialist holds a voting seat on the Emergency Medical Services for Children Advisory Committee. This Committee services to provide NYSDOH Commissioner with policy guidance on the pre-hospital health care needs of children including CSHCN.
- Parents of CSHCN spoke at public hearings sponsored by the MCHSBG Advisory Council.
- Healthy Start consumers met with Title V staff to discuss consumer involvement and focus groups.
- In April 2007, a Youth Advisory Committee was formed. Nineteen culturally diverse youth and young adults with special health care needs met with CSHCN Program staff. These representatives are providing NYSDOH with their perspectives on transition to adult care services and other issues. They have provided consumer input for the development of a statewide plan for transition resources.
- A Family Champion received a scholarship to attend the AMCHP annual meeting.
- The Department has invited its Title V staff and outside agency staff in planning a community engagement meeting to discuss pandemic flu planning for special needs populations, including families of children with special health care needs and young adults with special health care needs. Title V staff have been involved with recruiting families of CSHCN and young adults with special needs.
- The Genetic Service Project at Dor Yeshorim provides genetic testing for eight genetic diseases in adolescents in the ultra-Orthodox and Chasidic Jewish community. The information is used when the young adults are considering marriage to inform them if both members of the couple have disease-causing mutations for the same condition(s). Funds are also targeted for upgrading the computer system which stores the supporting databases, for validation of clinical validity and utility of new tests and for expanding the program into the modern Orthodox community.

Table 4a, National Performance Measures Summary Sheet

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program continued to employ a Family Specialist, the parent of a child with special health care needs, and several other employees		X		X
2. The Bureau of Child and Adolescent Health has expanded the diverse group of family representatives advising the Program on the development, implementation and evaluation of resources and tools.				X
3. The CSHCN Program continues to broaden parent input in policy development, improving access to health and related services for CSHCN, identifying and referring CSHCN to appropriate services, and collecting information to identify services gaps.				X
4. Conference calls are held with parent representatives.				X
5. A Youth Advisory Committee, consisting of culturally diverse youth representatives, has provided input on transitions tools, such as the portable health summary and transition software. The youth perspective drove the format of the portable health s				X
6. Parents of CSHCN spoke at public hearings sponsored by the MCHSBG Advisory Council.				X
7. The NYS Child Development Learning Collaborative was completed in October 2007. Parent representatives were included and integral to the project.				X
8. The CSHCN Program collects information about the needs expressed by the family to assist with program evaluation and design.				X
9. Healthy Start consumers met with Title V staff to discuss consumer involvement and focus groups.				X
10.				

b. Current Activities

- CSHCN Program staff continues to work with the parent involvement strategic plan formulated in 1999 to improve consumer input into MCH programs and policy development and as a blueprint for family involvement. The CSHCN Program continues to engage our cadre of Family Champions by seeking their perspectives on the development, implementation and evaluation of resources and tools for use by CSHCN families and the MCH programs that serve these families.
- The Early Intervention Program offered leadership training programs, informational bulletins, and parent membership on all clinical practice consensus panels. There is an active Parent Involvement Committee. Parents are represented on the governor-appointed advisory board and its task groups.
- The Early Intervention Program employs a Family Initiatives Coordinator, who is the parent of a child with a disability, to coordinate a range of parent initiatives.
- Parent involvement scores improved in 2007.
- The CSHCN Program designed a "Special Health Care Needs" web page. This page was posted on the Department's website. Resources pertaining to Family Support, Mental Health and Developmental Disabilities were developed and added to this web page. A portable health summary that can be downloaded by families for their use was added to this web page.

• The CSHCN Program hosted a second meeting of the Youth Advisory Committee (YAC) to share resources and tools developed with consumer input.

c. Plan for the Coming Year

• Continue to enhance the function of our cadre of Family Champions by seeking their perspectives on the development, implementation and evaluation of resources and tools for use by families and MCH Programs that serve families.
• The Family Champions will be engaged to provide perspectives on transition resources needed by their youth/young adults with special health care needs and themselves.
• Family representatives of the Child Development Learning Collaborative will continue to be involved.
• Quarterly conference calls will be maintained to keep family representatives abreast of program initiatives.
• Continue funding local health departments to assist CSHCN and their families.
• Continue to engage a diverse stakeholder group to advise the Department on the identification, recruitment, and training of family advisors (a.k.a. Family Champions) to the Title V Program. The stakeholders group includes representatives from the Department of Health and other state agencies (Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Developmental Disabilities Planning Council), family organizations (Parent to Parent, Family Voices, Families Together, and Parent Training and Information Centers). Family Champions will be provided with additional training, and engaged in CSHCN Program activities.
• The Youth Advisory Committee will continue to convene to assist the CSHCN Program with the statewide plan for transition resources.
• The SSDI project will disseminate results of consumer and parent focus groups.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	55	60	52	55	58
Annual Indicator	51.7	51.7	51.7	51.7	45.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	58	58	59	59	60

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

- CSHCN Program funds local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.
- Montefiore Hospital established the Bronx Alliance for Special Children, a comprehensive program for children with special health care needs and their families in the Bronx and upper Manhattan. The program screens its large pediatric outpatient department to identify children with special health care needs; 140 were identified as such. The program develops individual careplans provides care coordination, homevisits and supports to the families with the greatest needs. Some parents and families are integrated into the clinical teaching of the pediatric attendings. Clients' individual careplans averaged 2.5 goals per plan. Over the last two years, 76% of client goals have been achieved.
- In 2007, 63% or 3497 children with special health care needs served by the program reported having a primary care provider.
- CSHCN Program /2008/ is in cue to pilot test the CSHCN Information System. This system will provide relevant program data and make it easier for local programs to track the CSHCN treatment experience.
- Local health departments actively link lead poisoned children with special health care needs to appropriate services, if available in communities. In most cases, lead poisoned children are automatically given developmental tests and/or referred to the Early Intervention Program to ensure care coordination.
- SSDI continued to provide technical assistance to the program and to the genetics program.
- The Early Intervention Program assists children referred to the Early Intervention program to obtain a medical home, if not already connected to one.
- The Youth Advisory Council assisted the Program with identifying issues and concerns with transitioning to adult medical services and will continue to provide perspective to contribute to a statewide plan for transition resources and services.
- The American Indian Health Program and the Migrant and Seasonal Farmworker Health Program both work to improve access to comprehensive care and to establish a medical home for children. Because of the unique circumstances of migrant children, providers concentrate on connectivity and continuity of care along the migrant stream.
- The School Based Health Center Program provides onsite primary care in schools in high need areas. If the enrolled student has another community provider, school-based health center services are coordinated with that provider to help ensure continuity of care and to reduce unnecessary duplication of effort.
- Seven community-based cancer support contractors support children with cancer, or children whose parents or siblings have cancer.
- Increased the number of Healthy Children New York Child Health Promotion Specialists who can assist families in child care and other child-serving agencies to locate and enroll in a medical home.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program funds local county health departments to provide health information and referral, assistance with obtaining health insurance coverage, finding a medical home,		X	X	X

and linking with specialty care and other supportive services.				
2. The Children with Special Health Care Needs (CSHCN) Program completed the Child Development Learning Collaborative, in partnership with families of CSHCN, District II of the American Academy of Pediatrics, the American Academy of Family Physicians.	X	X		X
3. Montefiore Hospital established the Bronx Alliance for Special Children, a comprehensive program for children with special health care needs and their families in the Bronx and upper Manhattan.	X	X		X
4. The program is in the process of rolling out the pilot of the CSHCN Information System.				X
5. The CSHCN Program continued to collect information about the needs expressed by the family for evaluation and program design purposes.				X
6. The Early Intervention Program has an active Medical Home Workgroup to ensure children in their program have access to medical homes.	X	X	X	X
7. The Youth Advisory Council provided input on transition issues.		X		X
8. The American Indian Health Program and the Migrant and Seasonal Farmworker Health Program continue to work to improve access to comprehensive care and to establish a medical home for children.		X		X
9. Local health departments continued to link lead poisoned children to medical homes and the Early Intervention Program, and the Growing Up Healthy Hotline continued to make referrals to medical and health insurance programs for residents statewide.		X	X	X
10. 10. The School–Based Health Center Program provides onsite primary care in schools in high need areas and coordinates care with other community providers to ensure continuity of care and to reduce duplication of effort.	X	X		X

b. Current Activities

- The Growing Up Healthy Hotline continued to provide information to callers about access to medical homes for children.
- School-based health centers in New York coordinate care with other community providers to ensure continuity of care. They are required to provide access to care 24 hours per day, seven days per week.
- All New York State Department of Health Programs dealing with prenatal care (PCAP, MOMS, Community Health Worker) work with expectant parents to help find a provider for their baby.
- Title V staff completed the 19-month Child Development Learning Collaborative to improve developmental screening of children birth to five years of age. Early results suggest that this will facilitate development of practice-based change strategies and identify systems issues.
- NYS Title V staff have examined SLAITS data from NYS and include these data in all presentations for the CSHCN Program. Staff query the Data Resource Center for Child and Adolescent Health/Child and Adolescent Health Measurement Initiative data base.
- Some county CSHCN Programs are performing Medical Home outreach activities as part of the state CSHCN Program contracts with localities.
- CSHCN Program staff continue to assist families without medical homes to find medical homes for their children.
- Hotline activities continue.
- Discussions and informational sessions have been held with the Early Intervention

Program and the Developmental Disabilities Planning Council.

c. Plan for the Coming Year

- Local CSHCN Programs will continue to increase the percentage of CYSHCN through increasing the number of children who have a primary care provider and medical home. Upon a child's intake into the local CSHCN Program, program staff inquire whether a child has a primary care provider. If a child does not, local CSHCN Program staff will assist families in locating a primary care provider who participates in their insurance plan.
- Continue funding local health departments to provide CSHCN Program information and referral services and consumer involvement activities. Funds were added to local contracts to provide consumer stipends, child care, travel reimbursement and other costs associated with consumer meetings/trainings.
- Continue Medical Home/Child Development outreach and implementation by integrating the concepts into other Department initiatives, the school-based health center Asthma Learning Collaborative and regional asthma coalitions.
- The Physically Handicapped Children's Program (PHCP) will continue to provide reimbursement for diagnostic and treatment services for eligible children who are underinsured. PHCP authorized over 600 children to receive diagnostic evaluations. Participation by localities in the treatment program is voluntary in the form of state aid reimbursement for 50% of the county's expenditures. The state's capacity to assist families is limited by the degree that localities participate in the program.
- Local health department programs will continue to actively link lead poisoned children with special health care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned case automatically given an developmental screening and/or referred to local Early Intervention (EI) program to ensure care coordination.
- The Early Intervention Program has an active Medical Home Workgroup to ensure children in their program have access to medical homes.
- Continue the Youth Advisory Committee. Formulate a plan for transition resources and services.
- Continue to analyze the 2005/2006 SLAITS data. Use as 2005/2006 data as benchmarking for 2009.
- Continue Medical Home Workgroup under the Early Intervention Program.
- The American Indian Health Program and the Migrant and Seasonal Farmworker Health Program both work to improve access to comprehensive care and to establish a medical home for children. Because of the unique circumstances of migrant children, providers concentrate on connectivity with upstream and downstream providers.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	60	65	70	68	70
Annual Indicator	59.1	59.1	59.1	59.1	62.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?					
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	72	74	74		

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

- The Physically Handicapped Children's Program under the NYS Children with Special Health Care Needs Program continued to provide gap-filling coverage for children with special health care needs birth to age 21 for services that insurances will not cover or for children in special financial circumstances who are ineligible for Medicaid or Child Health Plus.
- Over 600 children received diagnostic evaluations under the Physically Handicapped Children's Program (PHCP). This program assists families who are underinsured to obtain a diagnostic evaluation for their child by reimbursing specialty providers for their services. Additionally, over 2,000 children were served through the PHCP Treatment Program.
- The CSHCN Program continued to collect information about the needs expressed by the family. A significant portion (~60%) of the CYSHCN who presented to the CSHCN Program needed gap filling assistance as their insurance was not adequate for treatment services. This need is reflected in national survey data as well. The 2005-2006 State and Local Integrated Telephone Survey shows that 34.7% of NYS families of CSHCN report their insurance is inadequate. Most commonly, families needed assistance with paying for deductibles, co-payments, and items not covered by or exceeding their benefit package.
- The CSHCN Program continued to fund local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.
- Each county within NYS has enrollment sites where families can be assisted to gain access to public insurance and fill out enrollment forms. Each local health department CSHCN Program is required to have a referral linkage to the facilitated enrollment agency in their area. In some cases, the facilitated enrollment program is within the same agency.
- NY uses a combined Medicaid, Food Stamps, Child Health Plus, Family Health Plus and WIC enrollment application.
- All children identified as uninsured and underinsured by the Childhood Lead Poisoning Prevention Program are referred to appropriate local public insurance enrollment source. Lead poisoned children and their families, without health insurance are directed to and assisted with enrollment in MA and/or Child Health Plus to expedite access to care. Systems are in place to help uninsured needing immediate medical attention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. The Physically Handicapped Children's Program under the NYS CSHCN Program continued to provide gap-filling coverage for over 2,000 CSHCN age birth to 21 for services/treatments their insurances will not cover. NOTE: 2007 data are incomplete at this t	X	X	X	X
2. Over 600 children were authorized to receive a diagnostic evaluation under the Physically Handicapped Children's Program (PHCP).	X	X		
3. The CSHCN Program continues to collect information insurance coverage and make referrals where needed.	X	X	X	X
4. The CSHCN Program continued to fund local county-level CSHCN programs.	X	X	X	X
5. Each county within NYS has enrollment sites where families can be assisted to gain access to public insurance and fill out enrollment forms. Each CSHCN Program is required to have a referral linkage to facilitated enrollers.		X		X
6. NY uses a combined Medicaid, Food Stamps, Child Health Plus, Family Health Plus and WIC enrollment application.		X	X	X
7. All children identified as uninsured and underinsured by the Childhood Lead Poisoning Prevention Program were referred to appropriate local public insurance enrollment source.		X		
8. DOH continued to revise and make available the Resource Directory for CSHCN.		X	X	X
9. The Family Champions and other family participants continued to advise the Program on coverage issues.				X
10. CSHCN parents participated in consumer focus groups.				X

b. Current Activities

There is discussion about changing the performance goals for this measure, but it is difficult to determine based on a single data point. There are no new SLAITS data this year. Program data differs significantly from SLAITS results. Performance targets will be modified when there is a second data point that indicates in what direction trends are moving.

The CSCHN Program formed a Youth Advisory Committee that is advising the program on transition issues. The result will be a statewide plan for transition resources and services. The Family Champions and Learning Collaborative parents are also working with the program and sharing their perspectives on coverage issues.

A new Medicaid waiver program has been developed for children in foster care under the age of 21 who have significant mental health, developmental disabilities or health needs. This waiver will allow payment for some services not normally provided through Medicaid, including family care giver supports and services, crisis respite, adaptive and assistive equipment and accessibility modifications that will enable the children to live in a home or community-based setting. The CSHCN Resource Directory has been updated to include information about this waiver.

c. Plan for the Coming Year

- Major changes are planned with regard to Medicaid or Child Health Plus coverage. Former Governor Spitzer planned to extend coverage to an additional 400,000 individuals. It is anticipated that changes will be made to how systems are accessed and what is required for certifications/re-certifications in order to make getting and staying insured easier for the consumer.
- The Physically Handicapped Children's Program will continue to provide reimbursement

for diagnostic and treatment services for those eligible children who are underinsured. Participation by localities in the Treatment Program is voluntary in the form of state aid reimbursement for 50% of expenditures. The state's capacity to assist families is limited by the degree that localities participate in the program.

- The CSHCN Program will continue to fund local CSHCN Programs to work with CSHCN and their families to ensure access to health insurance and medical homes.
- Local programs will continue to link with facilitated enrollers.
- The CSCHN Program will continue to work with the Family Champions, the Learning Collaborative families and the Youth Advisory Council in FFY 2009.
- When the new SLAITS data are available, program and Department staff will analyze areas of progress and lack of progress and alter program plans accordingly.
- The Resource Directory, which includes information about public insurance programs and services, will be reprinted and distributed to health care providers, child serving organizations and agencies, and consumers.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	80	85	78	80	82
Annual Indicator	75.3	75.3	75.3	75.3	90.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	91	92	92	92	93

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

- The CSHCN Program continued to fund local county health departments to provide health information and referral to CSHCN and their families, assisting them with obtaining health insurance coverage, finding a medical home, linking with specialty care and assisting with other service needs.

- The CSHCN Program, under authority of the Physically Handicapped Children's Program legislation, is authorized to approve Specialty Centers. Specialty Centers are expected to provide family-centered, comprehensive, culturally- and language-appropriate care. They are also expected to work in a coordinated fashion with the child's community-based medical home.
- The Early Intervention Program is funded by a Federal appropriation. EIP services are funded by state, county and insurance reimbursement. The EIP has strong ties to the MCHSBG programs and services, providing direct services to infants and young children who are identified as having a diagnosed condition or disability. The child find component under EI locates and tracks developmental surveillance of at-risk infants and their families and links families with appropriate services. EIP is a major source of MCH referrals. The Early Intervention Program continues to work with the Children with Special Health Care Needs Program on cross-program issues, such as parent involvement and sharing of data.
- The Early Intervention Program has two types of service coordination. The first type assists families through the initial phase of entry into the Early Intervention Program, helping them to deal with the multidisciplinary evaluation and development of the first Individualized Family Services Plan. The second type of service coordination is ongoing, designed to ensure that families are supported through all aspects of the Early Intervention Program and that EI services are coordinated with other services and supports offered to families from sources outside of the program.
- The Community Health Worker Program assists families to connect to health care services and sustain that connection.
- Consumer focus groups were asked about their experiences with accessing services. This information was shared with program managers and policy makers to ensure incorporation into program planning.
- The Congenital Malformations Registry staff sent informational mailings to notify families of children born with malformations of the Early Intervention Program and support groups available statewide.
- Local health department programs actively link lead poisoned children with special health care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned child is automatically given a developmental screening and/or referred to EIP.
- Regional Perinatal Programs are required to establish and implement referral networks to ensure that families have access to the appropriate services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CSHCN Program continued to fund local CSCHN programs to provide assistance to CSCHN and their families.		X	X	X
2. The CSHCN Program, under authority of the Physically Handicapped Children's Program, continued to approved Specialty Centers as needed.	X		X	X
3. EI provides services to infants and young children who are identified as having a diagnosed condition or a developmental disability.		X	X	X
4. The Early Intervention Program provided service coordination to some CSHCN who qualify.		X		X
5. The Community Health Worker Program assisted families to connect to health care services and sustain that connection.		X		
6. Consumer focus groups were asked about their experiences with accessing services. This information was shared with program managers and policy makers to ensure incorporation into program planning.				X
7. The Resource Directory for Children with Special Health Care		X	X	X

Needs continues to be distributed.				
8. The Congenital Malformations Registry staff sent informational mailings to notify families of children born with malformations of the Early Intervention Program and support groups available statewide.		X	X	X
9. Local health department programs actively link lead poisoned children with special health care needs to the appropriate services.		X	X	X
10. Regional Perinatal Centers utilize their established referral networks to ensure families receive needed follow-up services.		X	X	X

b. Current Activities

- The Medical Home Unit activities, including the Child Development Learning Collaborative, are organized to have an impact on the "family friendliness" of local systems of care.
- Local health department CSHCN Coordinators work with families and providers to enable needed referrals to specialty providers and other needed services.
- The Early Intervention Program continues to provide initial and ongoing service coordination.
- The CSHCN Program continues to seek input in conference calls with the Family Champions on how systems of care can be more responsive to family and consumer needs.
- The CSCHN Program will continue to work with the Youth Advisory Committee to get their input.

c. Plan for the Coming Year

There is a major expansion in health insurance coverage planned for the coming year. It is anticipated that changes will be made to how systems are accessed and what is required for certifications/re-certifications in order to make getting and staying insured easier for the consumer.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	10	20	7	7	9
Annual Indicator	5.8	5.8	5.8	5.8	38.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	40	40	40	43	43

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern

revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

- The Youth Advisory Committee (YAC) was formed in order to get input of consumers on issues related to the transition to adult health care and independence. The YAC's goal is for the youth to assist the CSHCN Program with formulating a statewide plan for transition resources and services.
- Transition activities were included in the local CSHCN workplans.
- Family Champions were queried about transition issues during needs assessment focus groups.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CSHCN Program sends out materials to children enrolled in the program who have reached transitional ages. Materials explain the need for transition planning and give key points to consider.		X		
2. Transition activities were included in the local CSHCN workplans.			X	X
3. Family Champions were queried about transition issues during needs assessment focus groups.				X
4. The Youth Advisory Council provided input on transition issues.				X
5. CSHCN Program staff monitor and provide technical assistance to local programs around transition issues.			X	X
6. CSHCN Program staff monitor and provide technical assistance to local programs around transition issues.		X		X
7. A hand-held record/health diary has been created that can ease in the transition. The document will be carried with the youth and will be a tool to comprehensive and coordinated services.			X	X
8.				
9.				
10.				

b. Current Activities

- CSHCN Program staff continues to work with the State Education Department on transition issues.
- CSHCN Program staff monitor and provide technical assistance to local programs around transition issues.

• Title V staff continue to utilize SLAITS data in understanding the status of this issue for NYS.
• Staff provide sessions for parents regarding transition of youth and importance to families.
• The Youth Advisory Committee has helped to identify what transition resources are needed for youth and helped the state CSHCN Program to formulate a plan to address transition issues. The youth representatives have engaged in usability testing of transition software and provided their comments regarding enhancements to make the software more consumer friendly.
• The CSHCN Program is working with other Youth Development groups for help and advice with inclusion of youth in policy development.
• A hand-held health summary has been developed that can ease in the transition of youth to adult health care. The document will be carried by the youth and will be a tool to promote comprehensive and coordinated services. The input of youth advisors drove the design of the Portable Health Summary (i.e., pocket size, color, cover design).
• The state CSHCN Program will address a statewide meeting of Regional Transition Coordinators about the transition resources and tools available through the Health Department.

c. Plan for the Coming Year

• DOH will continue to work with the State Education Department and the State on transition issues. Youth advisors have participated in testing the usability of transition software that is part of the Healthy Transitions Network. This network was developed with support from a Developmental Disabilities Planning Council grant and the Department has been collaborating in the user testing phase. The secure network consists of individual websites that link youth with one another and members of their transition team. Each website offers tools for transition planning and care coordination. The youth advisors reacted favorably to the software during the usability testing phase. The next step is the implementation of pilot project with students who are using the software in their transition planning. A pilot of the transition software is scheduled for this year.
• CSHCN staff will continue to monitor the performance of local programs on issues related to transition.
• CSHCN staff will continue to work on information systems development that will assist the program to track these activities.
• Continue working with the Youth Advisory Committee to evaluate resources and tools that have been developed and assess ongoing needs regarding successful transition from parental responsibility to self-responsibility, from pediatric to adult medical care and from school to work.
• Continue working with the Family Champions and other parent representatives on transition issues.
• Distribute the Portable Health Summary to health care providers, School Based Health Centers, schools and Transition Coordinators, and consumers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	79	81	85	86	87
Annual Indicator	78.8	83.3	81.6	83.5	85.8
Numerator					
Denominator					

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	88	89	90	90	90

Notes - 2007
Data from the National Immunization Survey. Numerator and Denominator data are not available. Data are for the time period 7/06-6/07.

Notes - 2005
Data is from the National Immunization Survey. Numerator and Denominator data are not available. Data are for the time period 1/04-12/04 (the latest available).

a. Last Year's Accomplishments

- The percent of 15 to 39 month olds with these immunizations has increased over the past five years, nearly reaching our projected performance objective.
- The Immunization Program provided vaccines through the NYS Vaccines for Children (VFC) Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted local health departments with disease surveillance and outbreak control activities, and continued to develop a statewide immunization registry. CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both central and regional offices and to purchase vaccines. County health departments assist in recruiting VFC providers.
- Over 90% of two year-old children in New York State (outside New York City) are vaccinated in private doctor's offices, not public clinics. Under the Provider-Based Immunization Initiative (PBII), county staff visit pediatricians and assess the medical records of their patients for compliance with immunization schedules. The information is then keyed into a computer using CDC-developed software, the Clinical Assessment Software Application, (CASA). CASA calculates the providers' immunization rate and enables them to improve their vaccination protocols, when necessary.
- Comprehensive Prenatal/Perinatal Services Networks provide education and outreach to engage children into the health care system. Some networks conducted outreach for Child Health Plus and to ensure that parents are aware of the need for comprehensive immunization.
- Welcome to Parenthood, a packet given to the family of each newborn born in New York, contains information about childhood immunizations.
- Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.
- Up-to-date immunizations were provided to over 1800 children in migrant day care settings in NYS.
- The Community Health Worker Program educated parents about immunization, assessed the immunization status of all children in the program, referred and assisted families to obtain immunization, and followed-up with families to assure they actually received the service. Assistance is given with insurance enrollment. /2008/In 2006, 89.3% of the children entering the program had up-to-date immunizations. Of the remaining children who did not, 75.6% received immunizations while in the program, and 14.7% were pending at the time the data were collected. A total of 97% had complete immunizations. In 2007, 73.3% of the children entering the program had up-to-date immunizations. Of the remaining children who did not, 83.2% received immunizations while in the program, and 5.3% were pending at the time the data were collected. A total of 80.3% had complete immunizations.
- PCAP and MOMS educated parents in the need for preventive services, including immunization. Assistance is given with health insurance enrollment.

- WIC reviews immunization records. In WIC, all infants and children are screened until all marker immunizations are received. Infants and children not adequately immunized must be referred to a health care provider or immunization clinic.
- Child care providers are required to check immunizations and refer.
- Age-appropriate immunizations are part of the comprehensive primary care services provided by school-based health centers (SBHC) for enrolled students. SBHCs, as extension clinics of Article 28 facilities, obtain vaccines through the Vaccine for Children's Program (VFC) and administer them to students who are eligible to receive vaccines through this mechanism. Students' immunization records are reviewed on a periodic basis to determine which students require a vaccine.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Immunization Program provided vaccines through the NYS Vaccines for Children Program, assessed immunization rates and worked to improve them, provided technical assistance to providers, disseminated educational materials, assisted providers.			X	X
2. Under the Provider-Based Immunization Initiative (PBII), county staff visit pediatricians and assess immunization records.			X	X
3. Comprehensive Prenatal/Perinatal Services Networks provided education and outreach to engage children into the health care system.		X	X	X
4. Welcome to Parenthood, a packet given to the family of each newborn born in New York, contains information about childhood immunizations.		X	X	X
5. Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supports immunization surveillance, tracking, parent and provider education and special studies.			X	X
6. Up-to-date immunizations were provided to over 1800 children in migrant day care settings in NYS.	X	X		X
7. The Community Health Worker Program educated parents about immunization, assessed the immunization status of children, referred and assisted families to obtain immunization, and followed-up with families to assure receipt of vaccines.		X		X
8. PCAP and MOMS also educated parents in the need for preventive services, including immunization. Assistance is given with health insurance enrollment.		X	X	X
9. In WIC, immunization records are reviewed and children who are not up-to-date are referred to health-care providers or immunization clinics.		X	X	X
10. School-based health centers administer age-appropriate vaccines, as part of comprehensive primary care. Enrolled students immunization records are reviewed on a periodic basis to determine if their immunizations are current. If necessary SBHC staff				

b. Current Activities

Implementation of the new statewide, computerized immunization registry system (begun in January 2008) will enable physicians to identify and track under-immunized children and raise immunization rates.

c. Plan for the Coming Year
Further development of the statewide electronic immunization registry, with increased reporting capability, is planned for the coming year.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	15	14	13	12	11
Annual Indicator	14.9	14.2	13.7	13.1	13.1
Numerator	5566	5415	5332	5214	5214
Denominator	373439	381221	390618	398091	398091
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	11	11	11	10	10

Notes - 2007
2006 data are being used as a proxy for 2007.

a. Last Year's Accomplishments
- The rate of births to teens 15-17 has steadily declined from 2001-2006, and is currently at 13.1 per 1,000 live births.
- The Family Planning Programs provide community education, comprehensive reproductive health care, a full range of contraceptive methods, counseling and testing for HIV, and screening and treatment for sexually transmitted diseases. Fifty-three family planning programs provided services to 333,578 individuals in 2006, and 26.2% were under the age of 20.
- The Community-Based Adolescent Pregnancy Prevention Program's goal is to reduce teen pregnancies in the highest risk zip codes (now 234 statewide) across New York State. C-BAPPP promoted abstinence and the delay of sexual activity among teens; encouraged educational, recreational and vocational opportunities as alternatives to sexual activity; taught assertiveness skills; and promoted access to family planning and comprehensive reproductive health services.
- Until October 1, 2007, NYSDOH funded 37 Abstinence Education and Promotion contractors to provide abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 10- to 19-year-olds. The focus was on junior high/middle school aged students. This initiative was discontinued effective September 30, 2007 due to increasingly onerous federal requirements for receiving Title V, Section 510 funds, and lack of evidence to support an abstinence-only model.
- The Comprehensive Prenatal/Perinatal Services Networks promoted reduction of adolescent pregnancy rates through provider and community conferences, outreach and education efforts. The Networks conduct education and outreach activities to improve the reproductive health of all women, including teens.
- Article 6 reimbursed local health departments with State Aid for health education and other population-based efforts, and support infrastructure needed to provide data collection, data

evaluation, community-based planning and implementing collaborative intervention strategies.

- The Rape Crisis Program developed and implemented policies designed to provide effective and compassionate care to victims of sexual assault and supported professional and community-based prevention education programs. NYSDOH developed and implemented a Sexual Violence Primary Prevention Committee (SVPPC). The SVPPC meets quarterly and is made up of approximately 30 members including, representatives from state and local agencies, community-based providers, advocacy organizations and the field of academics, The SVPPC shown a tremendous commitment to identifying and addressing issues related to sexual violence. The goal of this committee is to create a plan to prevent sexual violence in NYS through effective primary prevention programming. Currently the committee is in the process of a needs and resource assessment of the state to determine the scope of the problem.
- Risk assessment and anticipatory guidance and health education pertaining to sexual activity is a part of the initial assessment and annual comprehensive physical exam for adolescents enrolled in a school-based health center. When indicated, students have access to either onsite or referral for family planning services and pregnancy testing is done.
- ACT for Youth Centers for Excellence provided information statewide to youth serving providers regarding Positive Youth Development approaches towards adolescent pregnancy prevention.
- Healthy Start collaborations continued. The Department met with Healthy Start grantees in order to enhance communication and coordination among grantees and Title • The Healthy Start consumers serve as the advisory group for MCH focus groups conducted by SSDI.
- Teen focus groups were conducted and results shared.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Family Planning Programs provide community education, comprehensive reproductive health care, a full range of contraceptive methods, counseling and testing for HIV, and screening and treatment for sexually transmitted diseases.	X	X	X	X
2. The Family Planning Programs provide community education, comprehensive reproductive health care, a full range of contraceptive methods, counseling and testing for HIV, and screening and treatment for sexually transmitted diseases.			X	X
3. The Comprehensive Prenatal/Perinatal Services Networks promoted reduction of adolescent pregnancy rates through provider and community conferences, outreach and education efforts. The Networks conduct education and outreach activities.			X	X
4. Article 6 reimbursed local health departments for health education and other population-based efforts, and support infrastructure needed to provide data collection, data evaluation, community-based planning and implementing collaboratives.			X	X
5. The Rape Crisis Program developed and implemented policies designed to provide effective and compassionate care to victims of sexual assault and supported professional and community-based prevention education programs.	X	X	X	X
6. Risk assessment and anticipatory guidance and health education pertaining to sexual activity are part of the initial assessment and annual comprehensive physical exam offered in School-Based Health Centers. Pregnancy testing is done when indicated.	X	X		X
7. ACT for Youth continued its youth development focus, building assets for resiliency and resourcefulness among youth.			X	X

8. ACT for Youth Centers for Excellence provided information statewide and in various conferences on Youth Development concepts and best practices.				X
9. The Department met with Healthy Start grantees in order to enhance communication and coordination among grantees and Title V.				X
10. SSDI conducted teen focus groups. Results are disseminated to DOH programs.				X

b. Current Activities
There were no major changes in activities in this program year.

The Healthy Start consumer group continues to serve as the advisory group to the MCH focus group activity under SSDI.

c. Plan for the Coming Year
With the redirection of state funds formerly used for Abstinence-only education programs, a new initiative will be implemented to expand comprehensive sexuality education in schools and other community settings to provide teens with medically accurate information and life skills to equip them with the necessary tools that they need to make the crucial healthy life choices needed for a healthy adulthood. This was accomplished through the enhancement of the Community Based Adolescent Pregnancy Prevention contracts.
The transfer of the Adolescent Pregnancy and Parenting Services (APPS) program from the Office of Children and Family Services will allow for greater coordination of services for pregnant adolescents through 21 years of age. Twenty-six programs are funded through community based organizations across the state providing the following services: counseling; basic needs; academic education; health services; employment services; recreational services; parent education; housing services; child care; and, services for infants and children.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	50	60	40	30	35
Annual Indicator	38.2	27.0	27.0	27.0	27.0
Numerator	3961	10534	10534	10534	10534
Denominator	10369	39014	39014	39014	39014
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	40	40	45	45	45

Notes - 2007
2002-2004 data are being used as a proxy for 2007.

Notes - 2006
2002-2004 data are being used as a proxy for 2006.

Notes - 2005
2002-2004 data is being used as a proxy for 2005.

a. Last Year's Accomplishments
- The Bureau of Dental Health completed dissemination of dental surveillance data for each county. The surveillance grant was active across the State, enrolling children for oral health screening and referring children to dental care. In 2006, the Bureau gained approval to conduct Head Start/Early Head Start surveillance. Dental Public Health residents conducted open mouth examinations at 13 Head Start/Early Head Start Centers on 232 children. Surveillance data are currently being analyzed and will be made available to our community partners.
- Ongoing oral health services were available to all school-based dental health center enrollees. The School-Based Health Center Dental Program operates in 38 sites serving over 50,000 students. A full range of services are provided, including, but not limited to, education and outreach, screening, sealants, referral and follow-up. Some also provided onsite treatment services. Sites are staffed with a combination of dentists, dental hygienists and dental assistants. Dental students and residents also participated in these programs and were provided with professional development opportunities.
- Thirty-six School-Based Preventive Dentistry Programs continued to place sealants in 2007, serving over 50,000 children. This program targeted school children in low socioeconomic areas and provided children with a point of entry into the dental care system. Students were screened for adverse dental conditions and for the need for application of sealants. Sealant sites increased participation in their program each year. Children who need restorative oral health services are referred. All families in targeted school districts receive promotional and educational information, which appears to contribute to the program's success.
- Other dental programs also promote the use of sealants, including the Preventive Dentistry Fluoride Supplement Program, which provided 300 schools, day care and Head Start programs in non-fluoridated areas with fluoride supplementation. Over 100,000 children are reached through this initiative.
- Program entered into community partnerships involving parents, consumers, providers and public agencies for identifying and addressing community problems related to oral health. This community-based problem solving approach has help to identify effective interventions to suit community needs.
- The Bureau of Dental Health continues to fund a Technical Assistance Center at the Rochester Primary Care Network. The Center assists in building community-based organizations responsive to children's dental needs and provided consultation to developing projects.
- The New York State Oral Health Coalition four working committees (Access to Care, Communications and Social Marketing, Workforce Development and Public Policy) continued their activities on implementing the Statewide Oral Health Plan. Dr. Thomas Curran, an oral-maxillary surgeon who is also a member of the Maternal and Child Health Services Block Grant Advisory Council, was active in the formulation of the Oral Health Plan and remains active in the committee structure.
- Article 6 State Aid provided funding for dental health education to each county in New York.
- The Bureau of Dental Health revamped, updated and supplemented public education materials (including sealant brochures) based on a needs assessment of oral health stakeholders. Staff also continued to update the NYSDOH web pages on a regular basis to expand the oral health materials available to the public through the website.
- The American Indian Health Program offered dental services to approximately 2000 children under age 20 either onsite or via off-reservation referrals. The children's fluoride program is on-going for Pre-K through Grade 6.
- Dental services were offered to approximately 3500 children through our Migrant and

Seasonal Farmworker Health Program. Sealants are also promoted in this setting.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Bureau of Dental Health completed dissemination of dental surveillance data for each county and initiated surveillance activities at 13 Head Start/Early Head Start sites.				X
2. 36 School-Based Preventive Dentistry Programs continued to provide ongoing oral health screening and assessment to all dental health center enrollees, and placed sealants on over 50,000 children in low socioeconomic areas.	X	X		X
3. Other dental programs also promote the use of sealants, including the Fluoride Supplement Program, which provided over 100,000 children with fluoride supplementation in non-fluoridated areas through schools, day care and Head Starts.	X	X		X
4. The Bureau of Dental Health continued to fund a Technical Assistance Center at the Rochester Primary Care Network.		X		X
5. The NYS Oral Health Coalition4 working committees (Access to Care, Communications and Social Marketing, Workforce Development and Public Policy) continued implementation of the Statewide Oral Health Plan.	X	X	X	X
6. The Bureau of Dental Health continued to implement an oral health listserv.			X	X
7. Article 6 State Aid provided funding for dental health education to each county in New York.				X
8. The Bureau of Dental Health revamped, updated and supplemented public education materials (including sealant brochures) based on a needs assessment of oral health stakeholders. The Webpage was updated, too.			X	X
9. The American Indian Health Program offered dental services to approximately 2000 children under age 20 either onsite or via off-reservation referrals. Fluoride is offered to children Pre-K through Grade 6.	X	X	X	X
10. Dental services were offered to approximately 3500 children through our Migrant and Seasonal Farmworker Health Program. Sealants are also promoted in this setting.	X	X	X	X

b. Current Activities

- Thirty-one Preventive Dentistry Program contracts continued providing services in 2008.
- The Bureau of Dental Health continues to work with stakeholders on implementation of the statewide Oral Health Plan.
- The Statewide Oral Health Technical Assistance Center contract was awarded in 2008.
- Ongoing oral health screenings and referrals were provided for all school-based health center -- Dental (SBHC-D) enrollees.
- The Department, in collaboration with the State Education Department, established over 200 new School-Based Dental Center sites.
- The Bureau and its contractors continue to implement the CDC SEALS software in order to evaluate our school-based sealant programs.

c. Plan for the Coming Year

• Continue to promote the use of effective preventive services such as community-based fluoride, dental sealants, education and other innovative programs.
• Ongoing oral health screening and referral will be available to all School-Based Dental Health Center enrollees.
• Complete analysis of Head Start/Early Head Start surveillance data and disseminate results.
• Promote use of Dental Surveillance data.
• Continue implementation of the Statewide Oral Health Plan.
• Continue sealant program evaluation, using CDC SEALS software and contextual information provided by quarterly and annual report.
• Work with State Education to implement legislation requiring children entering school to provide a dental health certificate.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	0.6	0.5	0.5	1.1	1
Annual Indicator	0.7	2.2	1.3	1.3	1.3
Numerator	27	85	49	50	50
Denominator	3766916	3790880	3790880	3916635	3916635
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	0.9	0.9	0.8	0.8	0.8

Notes - 2007
2006 data are being used as a proxy for 2007.
The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

Notes - 2006
The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

Notes - 2005
The number of MV related deaths is based on the definition used by the NYS Department of Health, Bureau of Biometrics and Health Statistics.

a. Last Year's Accomplishments
• Childhood Injury Prevention Projects have built successful coalitions for injury prevention at the local level, reaching out to diverse segments of the community to ensure that the populace is well informed on issues related to childhood injury prevention.
• The Bureau of Injury Prevention performs traffic related research and conducts

surveillance of passenger, bicycle and pedestrian safety in NYS. The Bureau of Injury Prevention also represents the Department on the Governor's Traffic Safety Committee.

- The Emergency Medical Services for Children Project continued to compile data to assist providers in prevention activities and in further enhancing the pediatric trauma care system. 2005 NYS data show that motor vehicle crashes accounted for 19.8% of all pediatric trauma cases and are responsible for the largest percentage of all pediatric dead-on-arrival cases (about 35%).
- The Community Health Worker, PCAP and MOMS Programs all have extensive child safety components, which stress car seat use and other infant safety measures.
- Parents who are enrolled with Community Health Workers are given extensive information about childhood safety. Homes are assessed for hazards and workers role model positive parenting skills.
- American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters. Last year, a vehicular accident helped rally the tribal members to address alcohol/substance abuse, vehicle safety and risk reduction.
- PCAP and MOMS have an extensive health education agenda, including infant and child safety, use of safety seats, and burn prevention and other causes of infant injuries.
- All school-based health centers provide screening for psychosocial and health risk assessment beginning with the initial visit. Student and family education about safety issues and abuse are included.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Childhood Injury Prevention Projects have built successful coalitions for injury control at the local level, reaching out to diverse segments of the community to ensure that the populace is well informed on issues.			X	X
2. The Bureau of Injury Prevention performs traffic related research and conducts surveillance of passenger, bicycle and pedestrian safety in NYS. The Bureau of Injury Prevention also represents the Department on the Governor's Traffic Safety Committee			X	X
3. The Emergency Medical Services for Children Project continued to compile data to assist providers in prevention activities and in further enhancing the pediatric trauma care system. Motor vehicle crashes account for 19.8% of all pediatric trauma cas			X	X
4. The Community Health Worker, PCAP and MOMS Programs all have extensive child safety components, which stress car seat use and other infant safety measures. Parents who are enrolled with Community Health Workers are given extensive safety information		X	X	X
5. American Indian Nations with Community Health Worker Programs all have formalized car seat education components. Other reservation clinics promote vehicle safety during individual health education/risk reduction encounters.		X	X	X
6. All school-based health centers provide screening for psychosocial issues and complete health risk assessment beginning with the initial visit. Student and family education about safety issues and abuse are included.	X	X		
7.				
8.				

9.				
10.				

b. Current Activities
There are no major changes in programming.

c. Plan for the Coming Year
No major changes planned.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				40	43
Annual Indicator			37.2	50	50
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	51	52	53	54	55

Notes - 2007
2007 data are based on the 2004 birth cohort.
Data Source: National Immunization Survey - breastfeeding supplement

Notes - 2006
2006 data are based on the 2004 birth cohort.
Data source: National Immunization Survey - breastfeeding supplement.

Notes - 2005
2004 data are being used as a proxy for 2005.
Data are from the National Immunization Survey.

a. Last Year's Accomplishments
- State regulation requires each hospital to have a lactation consultant. Regulations specifically forbid the administration of anti-lactation drugs by standing order and the issuance of sample packs of formula without prescription.
- The Department of Health continued to support the New York State Institute for Human Lactation to increase the breastfeeding initiation and continuation rate and to provide continuing education on breastfeeding to physicians, midwives, nurses and other health care providers, helping them to promote and manage breastfeeding effectively. The Institute produces an annual videoconference called Breastfeeding Grand Rounds that addresses both clinical and public health issues related to breastfeeding and lactation. The statewide broadcast, with an audience of approximately 500 professionals annually, includes a clinical lecture, a public health lecture, discussion of case studies, and extensive opportunity for audience participation and questions.
- The Lactation Institute sponsored a satellite broadcast on the link between breastfeeding and mental health. Over 100 downlink sites participated, and post-production DVD and video

materials were distributed.

- For over 25 years, the WIC Program has been effective in reducing the incidence and prevalence of nutrition-related disorders of pregnancy, infancy and early childhood, specifically low birth weight, infant mortality and iron deficiency anemia. New York's WIC Program supports a service delivery system of 100 local agencies, 570 delivery sites, 4500 retail food vendors and 485,000 participants. Breastfeeding promotion and support activities were expanded into all local WIC agencies. WIC provides extensive support for lactation and breastfeeding.
- Breastfeeding initiation among PRAMS respondents was 76.1% in 2006, the latest year for which data are available. At one month postpartum, 62.3% of PRAMS respondents reported they were still breastfeeding.
- In 2005, 68.6% of WIC moms reported ever breastfeeding. At 12 months, 24.8% of WIC participants reported in 2005 that they were still breastfeeding. This is double the rate reported in 2001. This is the fourth year in a row for these data to show increases. In 2001, the ever breastfed rate for WIC moms was 60.1%; the rate has increased 6.5% since 2001. The WIC Program continues to support a culturally-diverse peer counselor program. Some WIC local agencies pay peer counselors through a USDA grant and state funds; these agencies have higher breastfeeding rates.
- National Immunization Survey data indicate that 75.4% of New York women reported breastfeeding. New York City women were more likely to breastfeed (82.1%). This is the first year that New York has reached the Healthy People 2010 goal for breastfeeding initiation.
- It is important to initiate discussion early. PCAP and MOMS encourage breastfeeding through education during prenatal care and at the postpartum visit.
- The Community Health Worker Program (CHWP) promotes breastfeeding and provides support and referrals for services. Home visits are conducted shortly after birth with ongoing visits. In 2007, 72% (up from 68.8%) of the women were breastfeeding at hospital discharge; 32% continued at least 6 months.
- The Networks developed and implemented several workshops on the importance of breastfeeding. Part of this strategy is to work with obstetrical nurses and hospital staff to encourage breastfeeding. Based on the work of the Networks, some hospitals developed breastfeeding support groups as a mechanism to provide ongoing support of breastfeeding women.
- A Center for Best Practices to Prevent Childhood Obesity was established to address the issues of overweight and obesity in pregnancy and infancy, including breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State regulation requires each hospital to have a lactation consultant. Regulations specifically forbid the administration of anti-lactation drugs by standing order and the issuance of sample packs of formula without prescription.			X	X
2. The Department of Health continued to support the New York State Institute for Human Lactation to increase the breastfeeding initiation and continuation rate. A satellite broadcast reached over 5,000 health professionals.			X	X
3. The WIC Program continued to support breastfeeding. WIC data system (PedNSS) data indicate that 66.8% of WIC children aged < 5 years were ever breastfed and 23.2% were breastfed at least 12 months. 8.9% were exclusively breastfed at least 3 months			X	X
4. Breastfeeding initiation among PRAMS respondents was 76.1% in 2005 and 62.3% at one month postpartum. National Immunization Survey data indicate NY has reached the HP 2010 goal.			X	X

5. PCAP and MOMS Programs encourage breastfeeding through education during prenatal care and at the postpartum visit.	X	X	X	X
6. The Community Health Worker Program (CHWP) continued to promote breastfeeding. CHWs provided support and referrals for services at early postpartum home visits.		X	X	X
7. The Comprehensive Prenatal/Perinatal Services Networks developed and implemented workshops on the importance of breastfeeding.			X	X
8. Several networks linked with obstetrical nurses. Breastfeeding support groups were developed.	X	X	X	X
9. The Bureau conducts periodic hospital surveys to monitor breastfeeding rates, and is currently implementing a Statewide Perinatal Data System that will allow, among other things, more detailed assessments of breastfeeding rates and trends.				X
10. The Bureau of Women's Health responds to inquiries about the Department's K through 12 breastfeeding education materials. Materials are posted on the DOH website http://www.health.state.ny.us/nysdoh/b_feed/index.htm				X

b. Current Activities
The WIC Program continues to add new local agencies annually who pay peer counselors for their work to promote breastfeeding.

c. Plan for the Coming Year
No major changes are planned.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	96.4	99.9	98.8	97.9	97.9
Numerator	227848	240577	242628	242212	242212
Denominator	236259	240921	245675	247352	247352
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
2006 data are being used as a proxy for 2007.

a. Last Year's Accomplishments
• New York continued to monitor newborn hearing screening rates through the Universal Newborn Hearing Screening Program.

- In 2006, New York screened 98% of infants discharged from hospitals for hearing loss. In the first three quarters of 2006, the screening rate was again 98%. The average age for referral was not available in 2005 or 2006, due to a change in CDC reporting.
- The Department continued to support hospital-based newborn hearing screening programs through technical assistance and data maintenance. Program and Data Unit staff maintain data reporting requirements and continue to refine data collection and management protocols.
- Early Intervention Guidance Memorandum 2003-03 on Newborn Hearing Screening is disseminated on an ongoing basis. The document contains guidance on newborn hearing screening, the program requirements for maternity hospitals and birthing centers, and the role of the Early Intervention Program in facilitating follow-up for infants referred.
- Program staff provided ongoing training and technical assistance to local Newborn Hearing Screening Program managers and to local Early Intervention Programs. Quality Improvement efforts targeted data collection from the state's 147 maternity hospitals/birthing centers.
- Although the Community Health Worker Program does not screen for hearing loss, the program uses the Ages and States Questionnaire (ASQ), a parent-completed developmental screening tool. Through this process, the Community Health Worker program can potentially identify issues related to the child's development that could include hearing loss. The program refers to the Early Intervention Program, as appropriate. In 2006, there were 170 referrals made to the Early Intervention Program as a result of ASQ screening. Of these referrals, 84% were completed. In 2007, there were 225 referrals made to the Early Intervention Program as a result of ASQ screenings. Of these referrals, 92.4% were completed.
- The program continued to make award-winning educational materials available to the public.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In the first 3 quarters of 2007, 98% of infants discharged from New York hospitals were screened for hearing loss. Average age for referral is decreasing to around 4 months. In 2006, approximately 98% of all infants where screened for hearing prior	X	X	X	X
2. The Department continued to support hospital-based newborn hearing screening programs through technical assistance and data maintenance.				X
3. Early Intervention Guidance Memorandum 2003-03 on Newborn Hearing Screening is disseminated on an ongoing basis.				X
4. Program staff provided ongoing training and technical assistance to local Newborn Hearing Screening Program managers and to local Early Intervention Programs. Quality Improvement efforts targeted data collection methods.				X
5. Although the Community Health Worker Program does not screen for hearing loss, the program uses the Ages and States Questionnaire (ASQ), which resulted in 2007 in 225 referrals to the Early Intervention Program.		X		X
6. DOH continues to reinforce links between newborn hearing screening and the Early Intervention Program and continues to target data improvement.			X	X
7. Award winning public education/parent education materials on newborn hearing screening are available in six languages.			X	X

8.				
9.				
10.				

b. Current Activities

- Currently, all hospitals have systems for testing, tracking and reporting newborn hearing screening. DOH continues to provide technical assistance to hospitals and other constituents on newborn hearing screening program implementation.
- DOH continues to reinforce links between newborn hearing screening and the Early Intervention Program and continues to target data improvement.
- Award winning public education/parent education materials on newborn hearing screening are available in six languages.

c. Plan for the Coming Year

- Continue efforts to establish data-driven quality assurance and review protocols, and to continue provision of technical assistance on newborn hearing screening for hospitals and other constituents, with an emphasis on follow-up for infants who do not pass their initial hearing screening and/or who are suspected of having a hearing loss.
- Continue training efforts on the Hearing Disorder Clinical Practice guidelines on assessment and intervention. The training will focus on issues related to hearing loss in young infants to other groups, such as early intervention service providers, physicians and primary health care providers.
- Enhance Universal Newborn Hearing Screening (UNHS) program tracking and surveillance system to accurately identify, match, and collect unduplicated, individual identifiable data at the state level.
- Enhance the capacity of the UNHS Program to accurately report the status of every occurrent birth as part of NYS's progress in meeting the Healthy People 2010 goals

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	6	5	9	8.5	8
Annual Indicator	9.4	8.6	7.7	8.4	8.4
Numerator	432000	396000	347000	380000	380000
Denominator	4572000	4604000	4534000	4547000	4547000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8	7.5	7	6.5	6.5

Notes - 2007

2006 data are being used as a proxy for 2007.

a. Last Year's Accomplishments

- Children ages one through five years were eligible for Medicaid at 133% of the Federal Poverty Level (FPL) for twelve months of continuous coverage, even if their family's income exceeded eligibility levels during that year. Children ages six through 18 years of age were eligible for Medicaid at 100% of the FPL.
- Since November 2000, pregnant women and infants were eligible at or below 200% of poverty. All infants born to mothers enrolled in PCAP were MA-eligible for at least the first year of life. PCAPs also refer to programs such as Child Health Plus and/or Family Health Plus as appropriate. The Department has developed an application for all programs to help simplify the application process.
- Eligibility for Family Planning coverage was available up to 200% of poverty, regardless of previous pregnancy or eligibility. Under this waiver, the Federal government pays 90%, the State 10%, and there is no local share. FPBP screens every enrolled family for eligibility for public insurance.
- Facilitated enrollers are available statewide to assist families with public insurance enrollment processes.
- Children's Medicaid is called Child Health Plus A to avoid the stigma associated with Medicaid.
- Families at or below 250% of the Federal Poverty Level are eligible for Child Health Plus B (New York's State Child Health Insurance Program). Families over 250% of FPL are eligible for participation at full premium.
- Comprehensive Prenatal-Perinatal Services Networks facilitate the implementation of Medicaid Managed Care within their catchments area. Many Networks are facilitated enrollers for health insurance programs. Networks provide outreach, information and education regarding Managed Care and have the ability to identify new and emerging issues related to managed care.
- All MCHSBG funded programs are required to facilitate enrollment in insurance.
- Children with Traumatic Brain Injury injured before the age of 18 are eligible for Medicaid under a special waiver.
- CSHCN who did not have a source of insurance were assisted by the CSHCN Program to enroll in an insurance program, if eligible.
- The Community Health Worker Program (CHWP) assists any child or member of an enrolled family to access health insurance. Success rates are tracked. In 2007, 8.4% of children entering the CHWP did not have any health insurance. Of these children, 84.6% were subsequently enrolled in Medicaid and 9.5% were pending at the time of data collection. Of those ineligible for Medicaid, 75% were successfully enrolled in Child Health Plus.
- The insurance status for all students enrolled in school-based health centers is determined as part of the initial enrollment process. A facilitated enroller works with students/parents/guardians with no insurance to connect them to Child Health Plus and Medicaid.
- All children identified as uninsured and underinsured by the Childhood Lead Poisoning Prevention Program continue to be referred to appropriate local public insurance enrollment source. Lead poisoned children and their families, without health insurance are directed to and assisted with enrollment in MA and/or Child Health Plus to expedite access to care.
- Systems are in place to help uninsured needing immediate medical attention.
- Healthy Children New York increased the number of child health consultants who assist children in child care to obtain insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Children ages 1-5 years of age were eligible for Medicaid at 133% of the Federal Poverty Level (FPL) for twelve months of continuous coverage, even if their family's income exceeded			X	X

eligibility levels during that year. Children ages 6-19 at 100%				
2. Since November 2000, pregnant women and infants were eligible at or below 200% of poverty. All infants born to mothers enrolled in PCAP were MA-eligible for at least the first year of life. PCAPs also refer to programs such as Child Health Plus.			X	X
3. Eligibility for Family Planning coverage is available up to 200% of poverty, regardless of previous pregnancy or eligibility. Under this waiver, the Federal government pays 90%, the State 10%, and there is no local share.			X	X
4. Facilitated enrollers are available statewide to assist families with public insurance enrollment processes. All MCHSBG funded programs are required to facilitate enrollment in insurance.		X	X	X
5. Families at or below 250% of the Federal Poverty Level are eligible for Child Health Plus B (New York's State Child Health Insurance Program). Families over 250% of FPL are eligible for participation at full premium.			X	X
6. Comprehensive Prenatal/Perinatal Services Networks facilitate the implementation of Medicaid Managed Care within their catchments area. Many Networks are facilitated enrollers for health insurance programs.			X	X
7. Children with Traumatic Brain Injury injured before the age of 18 are eligible for Medicaid under a special waiver.			X	X
8. CSHCN who did not have a source of insurance were assisted by the CSHCN Program to enroll in an insurance program, if eligible.		X	X	X
9. The Community Health Worker Program (CHWP) assists any child or member of an enrolled family to access health insurance. Success rates are tracked.		X		
10. The insurance status for all students enrolled in school-based health centers is determined as part of the initial enrollment process and a facilitated enroller works with students/parents/guardians with no insurance to connect them to Child Health P		X		X

b. Current Activities

NYSDOH is in the process of preparing for a major expansion in coverage for the uninsured. The Governor had announced his intention to extend public insurance to all eligible uninsured families under 400% of the Federal Poverty Level. Current eligibility levels are always available on the NYSDOH public website: www.health.state.ny.us or www.nyhealth.gov. All public health programs will be involved in finding and enrolling unenrolled, eligible families.

CSHCN staff are monitoring the quarterly reports of local contactors to ensure that insurance status is recorded and analyzed. The goal is to ensure that insurance status is recorded 100% of the time.

c. Plan for the Coming Year

Major changes are planned, i.e., a major expansion in the public insurance programs.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				32	31
Annual Indicator			32.1	32.0	32.0
Numerator			24562	63874	63874
Denominator			76566	199608	199608
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	30	29	29	28	28

Notes - 2007
2006 data are being used as a proxy for 2007.

Notes - 2005
Numerator and demonminator data is not available.

a. Last Year's Accomplishments

- The Division of Chronic Disease Prevention and Adult Health and the Bureau of Dental Health in the Division of Family Health collaborated to complete surveillance of third-graders across the state. Height, weight and BMI measurements were added to an existing dental surveillance project. Dental hygienists were trained to accurately gather and record anthropometric data while completing oral screening.
- Obesity data are available both from the WIC program and from the Youth Risk Behavior Survey. There are also data collection efforts associated with individual community-level interventions.
- The Department continued to support the Eat Well, Play Hard (EWPH) program. The program is an intervention to prevent childhood overweight and long-term risks for chronic disease by promoting healthy eating habits and increased physical activity. The EWPH strategies targeted to children ages 2 and older are: increase the amount of developmentally-appropriate physical activity; increase consumption of fruits and vegetables; and increase consumption of 1% or less milk and low fat dairy products. Two key EWPH initiatives include the EWPH Community Projects and the EWPH in Child Care Settings initiatives. In 2007, 15 new EWPH Community Projects, covering 23 counties, received grants from NYS to develop local childhood obesity prevention partnerships targeting low-income children and their families. EWPH in Child Care Settings, an obesity prevention intervention targeting pre-school children, their parents, and child care center staff, was implemented in 14 low-income child care centers during FFY 2006 and 73 low-income child care centers during FFY 2007. Since October 2007, another 58 centers have received the intervention, bringing the total number of centers who have received the intervention to 145. The intervention reaches children and families in 31 counties plus 3 NYC boroughs.
- The Bureau of Health Risk Reduction implemented a program for the prevention of childhood overweight and obesity, formerly known as Activ8Kids!. The components of the program include: centers for best practices, school and community partnerships, and initiatives in the child care setting.
- Centers for Excellence in the Treatment of Eating Disorders were conceived and established.
- A project to encourage physicians to track BMI was completed under the Preventive Medicine Residency and the Bureau of Child and Adolescent Health. The study provided a

baseline for physician practice related to BMI-for-age, an educational intervention, and follow-up evaluation. Subsequently, Pediatric BMI Screening Toolkits were developed and distributed to 25,000 pediatric health care providers statewide by the Division of Chronic Disease Prevention and Adult Health, Bureau of Health Risk Reduction.

- The WIC Program provides nutrition information to all participants. The WIC Program has incorporated EWPH strategies into program policies, resources, guidelines, and interventions, and focuses on obesity prevention by offering WIC local agencies funding to promote healthy lifestyles, prescribing nutritious food packages, and providing participant-centered nutrition counseling/education. Fit WIC, a physical activity initiative, has trained WIC local agency staff at all 100 agencies from January 2005 to June 2007 on how to motivate WIC families to focus on good health and physical activity rather than weight. Fit WIC teaches simple age-appropriate movements, and incorporates games and activities that support a life-long habit of staying active. The WIC Program also has a Special Projects Grant funded by USDA to support Fit WIC research.
- Division of Chronic Disease Prevention and Adult Health tested new interventions that utilize concepts of social marketing and diffusion of innovation on a community-wide level in fourteen Head Start centers, ten of which served as controls. Interventions included assessment of food and activities policies, environmental assessment, collaborative policy development, and development of training sessions/materials for staff and families. Environmental and policy changes promoted an increase in physical activity, a decrease in TV/video viewing and language and policies that promote overeating and inactivity. A community-wide intervention component supported program changes.
- Health educational materials were constructed and made available through the NYSDOH publications catalog and on the public website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Division of Chronic Disease Prevention and Adult Health and the Bureau of Dental Health in the Division of Family Health collaborated to complete surveillance of third-graders across the state. Height, weight and BMI measurements.			X	X
2. Obesity data are available both from the WIC program and from the Youth Risk Behavior Survey. There are also data collection efforts associated with individual community-level interventions.			X	X
3. The Department continued to support the Eat Well, Play Hard program. The program is an intervention to prevent childhood overweight and long-term risks for chronic disease by promoting healthy eating habits and increased physical activity.			X	X
4. The Eat Well, Play Hard Community Projects program funded 15 new sites covering 23 counties.			X	X
5. Eat Well, Play Hard in Child Care Settings was implemented in 73 additional low-income child care centers during FFY 2007.			X	X
6. The Bureau of Health Risk Reduction continued to implement a program for the prevention of childhood overweight and obesity, formerly known as Activ8Kids!			X	X
7. BMI wheels were distributed to physicians. Follow-up questionnaires determined change in practice.			X	X
8. FitWIC, a physical activity initiative, was implemented in 2005. The WIC Program offers/provides participant-centered nutrition counseling/education promoting physical activity.			X	X
9. Division of Chronic Disease Prevention and Adult Health			X	X

tested new interventions that utilize concepts of social marketing and diffusion of innovation on a community-wide level in fourteen Head Start centers. ten of which will serve as controls.				
10. Health education materials were improved.			X	X

b. Current Activities

- Local data from the oral health/BMI surveillance project are now being analyzed and there is a plan to disseminate these data.
- North Bronx Health Network, with Jacobi Hospital, provides a Pediatric Obesity Clinic providing comprehensive multi-disciplinary programs to overweight and obese children 3-18 years of age and their families. The program has medical, nutritional, educational, psycho-social and physical activity components and focuses on improving prevention, detection and management of childhood obesity. All residents meet with a nutritionist during their community pediatrics rotation and participate in the nutritionist's patient interventions in the clinic. Services have been provided to 712 children during the three years of operation. With an average of 4 visits per patient, the project had demonstrated a significant decrease in BMI z scores across each client age group.
- Brookdale Hospital is working with obese and overweight children and adolescents who have one or more associated metabolic disorders of obesity. The program is providing treatment, nutrition, education, supervised physical activity and behavior modification to 197 obese and overweight children, as well as working with their families, and also works with primary care providers to assist them in identifying, assessing and providing follow-up to obese children. 61% of patients decreased their BMI z score; 53% reduced their cholesterol and 43% reduced blood pressure.

c. Plan for the Coming Year

In addition to continuing current activities:

- 112 more low-income centers are scheduled to implement the Eat Well, Play Hard in Child Care Settings intervention during the remainder of the current FFY. The intervention reaches children and families in 31 counties plus 3 NYC boroughs.
- As part of the recent tenth anniversary of EWPH, two additional strategies were added: incorporate screen time limits and increase the initiation, duration and exclusivity of breastfeeding.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				15	14
Annual Indicator			15	12.2	12.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2008	2009	2010	2011	2012
Annual Performance Objective	14	13	12	11	11

Notes - 2007
2006 NYS PRAMS data, exclusive of NYC, are being used as a proxy for 2007.

Notes - 2005
Data are from the NYS Prams Survey and are for New York Sate excluding New York City. The latest data available for this measure is 2003.

a. Last Year's Accomplishments
This measure is similar to a previously-selected NYS Performance Measure.

- These data are tracked and reported via PRAMS.
- Efforts to reduce smoking in pregnant women are a part of the multi-pronged efforts to reduce smoking in the general public. These efforts include: a coordinated set of evidence-based activities implemented by the tobacco control program: Community Partnerships work to change the community environment to support the tobacco free norm; Youth Action partners work with youth activists to change community norms and de-glamorize and de-normalize tobacco use; Cessation Centers work with health care organizations and providers to implement systems to screen patients for tobacco use and provide help; statewide media and counter marketing including TV, radio, outdoor, print and internet advertising with the goals of educating New Yorkers about the health risks of tobacco use and the dangers of second hand smoke, motivating tobacoo users to stop, and promoting use of the NYS Smokers' Quitline and Quitsite. (1-866-NY-QUITS, www.nysmokefree.com) Counter-marketing efforts seek to expose the manipulative and deceptive marketing practices of the tobacco industry, de-glamorize tobacco use, and build and sustain a tobacco-free norm.
- PCAP promotes healthy behaviors during pregnancy. PCAPs provide information regarding the impact of smoking on the woman and the fetus and have developed various programs to deal with smoking, including individual counseling and referrals to group or other programs that support smoking cessation.
- The School Health Program continued to screen for tobacco use and make appropriate referrals, including to obstetrical services and smoking cessation programs, and to counsel students accordingly.
- The Comprehensive Prenatal-Perinatal Services Networks' priorities included developing and implementing programs to reduce the number of women who smoke or use other substances during pregnancy. Networks provide education and training to health and human services providers on ways to assist women to enhance healthy behaviors, including smoking cessation.
- Although the Community Health Worker Program does not keep specific data on smoking, an important role of the Community Health Worker is to provide education for women to increase their understanding of behaviors that pose a risk to health. This includes the use of tobacco. The Community Health Worker will not only provide this information, but will provide appropriate referrals for those women seeking assistance in this area, including accompanying them to care, if necessary.
- Family Planning Programs refer for smoking cessation.
- All Migrant and Seasonal Farmworker Health and American Indian Health Program providers screen for tobacco use and make appropriate referrals.
- School-based dental health center staff continue to screen all enrollees, including pregnant adolescents, for tobacco-use, provide counseling and make appropriate referrals.
- New York State continued to enforce the Clean Indoor Air Act.
- NYS Medicaid covers smoking cessation products and programs.
- The Tobacco Control Program funded the American Cancer Society for "Make Yours a Fresh Start, a program working with pregnant women.
- A WIC Program in New York City was funded to do a smoking cessation encounters with pregnant and parenting women. All WIC local agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants regarding their use of tobacco.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. New York continued to invest in anti-smoking messages. Efforts to reduce smoking in pregnant women are a part of the multi-pronged efforts to reduce smoking in the general public.			X	X
2. PCAP and WIC promote healthy behaviors during pregnancy. PCAPs and WICS provide information regarding the impact of smoking on the woman and the fetus and have developed various programs to deal with smoking, including individual counseling and refe			X	X
3. The School Health Program continued to screen for tobacco use and make appropriate referrals, including to obstetrical services and smoking cessation programs, and to counsel students accordingly.	X	X	X	X
4. The Comprehensive Prenatal/Perinatal Services Networks' priorities included developing and implementing programs to reduce the number of women who smoke or use other substances during pregnancy.			X	X
5. Although the Community Health Worker Program keeps no specific data on smoking, an important role of the Community Health Worker is to provide education for women to increase their understanding of behaviors that pose a risk to health and refer accor		X	X	X
6. Family Planning Programs refer for smoking cessation.	X	X	X	X
7. All Migrant and Seasonal Farmworker Health and American Indian Health Program providers screen for tobacco use and make appropriate referrals.	X	X	X	X
8. School-based dental health center staff continue to screen all enrollees, including pregnant adolescents, for tobacco-use, provide counseling and make appropriate referrals.	X	X	X	X
9. New York State continued to enforce a tough Clean Indoor Air Act.			X	X
10. NYS Medicaid covers smoking cessation products and programs.	X	X	X	X

b. Current Activities

- New York continued to invest heavily in anti-smoking efforts.
- The Center for Environmental Health monitors implementation of the Clean Indoor Air Act. The Tobacco Control Program contracts with an independent evaluator to evaluate programmatic efforts.
- All WIC local agencies are required by policy to screen all prenatal, postpartum and breastfeeding participants and regarding their use of tobacco.
- Pregnancy Nutrition Surveillance System data reflects cigarettes/day -3 months prior to pregnancy collected on prenatal and postpartum participants.
- All PCAPs will continue to screen pregnant women for tobacco use, counsel them about the need to quit or reduce smoking while pregnant, and refer women to services, as needed, to assist them with quitting.
- No major changes

c. Plan for the Coming Year
No major changes are planned.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	4.6	4.4	4.2	4.1	4.1
Annual Indicator	4.5	5.2	3.9	4.0	4.0
Numerator	57	68	52	51	51
Denominator	1279454	1297818	1318372	1289480	1289480
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4	4	3.9	3.7	3.7

Notes - 2007
2006 data are being used as a proxy for 2007.

a. Last Year's Accomplishments
- Bureau of Injury Prevention and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning.
- The Office of Mental Health (OMH) was given the lead in all suicide prevention activities in the state. OMH continued to make available their prevention campaign. Title V programs have access to the campaign and associated materials. /2008/OMH funds community mental health services that include suicide prevention and crisis hotlines.
- Teen alcohol use is correlated with suicide attempts. The New York State Office of Alcohol and Substance Abuse Services (OASAS) continued to make available their campaign entitled, "Underage drinking: Not a minor problem." The package includes fact sheets and resource directories. MCHSBG Advisory Council members were also presented with this package. Title V programs have access to the campaign and associated materials.
- The School-Based Health Center Program includes an evaluation for suicide risk as a part of the initial health assessment and whenever indicated, as crisis intervention visits. Mental health services, including crisis intervention, were available through the school-based health center or by referral. Referrals may also have been made for more intensive consultation or treatment. School staff, family members and other students are also offered consultation and education. Approximately 25% of SBHC visits indicated emotional problems as a primary reason for the visit.
- An Office of Mental Health initiative continued to operate expanded school-based mental health services in five schools. This initiative provides a range of psychological support, education, consultation and treatment for students and families, co-located with a comprehensive school-based health center. School staff education and support were also an integral component of the model.
- Assets Coming Together (ACT) for Youth focuses community attention on asset-building activities for youth as a way of reducing risk-taking behaviors. Through these community

collaborations, ACT for Youth has developed youth forums on violence abuse and risky sexual behaviors, as well as peer education materials, conflict resolution training to train peer mediators, and mentoring programs.

- NYS continued implementation of the Lesbian, Gay, Bisexual and Trans-gendered Health Initiative. Over half of the grantees under this initiative are focused on issues related to gay and lesbian youth and issues with alcohol, substance abuse and self-inflicted injuries. Data from other states indicate that gay, lesbian and bisexual youth are approximately 4 times more likely to attempt suicide than their heterosexual counterparts.
- The Sexual Violence Primary Prevention Committee (SVPPC), as part of the needs assessment being conducted, is looking at data associated with other forms of violence as risk factors for victimization or perpetration of sexual violence. Studies also show that over one half of rapes and sexual assaults occur to women between the ages of 12 and 24. Although it is difficult to document the true prevalence of sexual violence, studies indicate that 1 in 6 of adult females and 1 in 33 of adult males have been victims of rape or attempted rape. More than half of all rapes of females occurred to women younger than 18; 22 percent occurred to females younger than 12. In approximately 8 out of 10 cases (83 percent) the victim knew the perpetrator. Victims of sexual violence are left with emotional scars such as fear, anger and anxiety which can lead to depression or suicide attempts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Bureau of Injury Prevention and the Public Health Information Group make suicide data available and are able to perform additional analyses for use in planning.			X	X
2. The Office of Mental Health (OMH) was given the lead in all suicide prevention activities in the state. OMH continued to make available their prevention campaign. Title V programs have access to the campaign and associated materials.			X	X
3. Teen alcohol use is correlated with suicide attempts. The New York State Office of Alcohol and Substance Abuse Services (OASAS) continued to make available their campaign entitled, “Underage drinking: Not a minor problem.”			X	X
4. OMH continued to operate an expanded school-based mental health initiative in 5 schools. This initiative co-located a comprehensive mental health services clinic with school-based health centers.	X	X	X	X
5. Assets Coming Together (ACT) for Youth focuses community attention on asset-building activities as a way of reducing risk-taking behaviors. Through these community collaborations, ACT for Youth has developed youth forums on violence/abuse.			X	X
6. NYS continued implementation of the Lesbian, Gay, Bisexual and Trans-gendered Health Initiative.			X	X
7. There is continued collaboration with the Bureau of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention, Office of Mental Health and Office of Children and Family Services.			X	X
8. The Sexual Violence Primary Prevention Committee will continue to work towards the ultimate goal of stopping sexual violence before it occurs. Some of the potential activities to accomplish this include developing or partnering with existing mentorin		X	X	X
9.				

10.				

b. Current Activities
There have been no major changes in programming. Title V will continue to collaborate with partners in suicide prevention.

c. Plan for the Coming Year
We plan continued collaboration with the Bureau of Chronic Disease Prevention and Adult Health, Bureau of Injury Prevention, Office of Mental Health and Office of Children and Family Services.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	85	87	90	91	92
Annual Indicator	86.2	87.2	87.1	88.6	88.6
Numerator	3436	3453	3281	3345	3345
Denominator	3986	3962	3765	3774	3774
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	92	94	94	95	95

Notes - 2007
2006 data are being used as a proxy for 2007.

Notes - 2006
2006 data have been updated and finalized.

a. Last Year's Accomplishments
• In 2007, largely as a result of mergers and closures, there was a reduction in the original 157 birthing hospitals that had been assigned a designated service level for purposes of perinatal regionalization; currently147 birthing hospitals have perinatal designations, including: 68 Level 1 hospitals, 25 Level 2 hospitals, 35 Level 3 hospitals, and 19 hospitals constituting 17 Regional Perinatal Centers. Staff of the Bureau of Women's Health continued to work with designated hospitals over the past year.
• The Bureau of Women's Health has continued to support the 11 Regional Perinatal Forums that combine the expertise of the hospital provider community with the expertise of the non-hospital community to bring a public health perspective to the regionalization process. Regional Perinatal Centers and Comprehensive Prenatal-Perinatal Services Networks collaborate in the development and the governance of the Forums. Forum membership includes a range of community-based agencies that provide prenatal care, local March of Dimes, Community Health Worker Programs and others. There is one Forum in each borough of New York City, one on

Long Island, and five in Upstate, providing full statewide representation.

- Bureau of Women's Health staff worked with the New York City Department of Health and Mental Hygiene to implement a City-wide Forum that brought together hospitals, community providers of ancillary services, and advocates to discuss issues across New York City.
- All Prenatal Care Assistance Programs (PCAPs) conduct risk assessment on all patients to identify any high risk factors that warrant appropriate follow-up. They have agreements with tertiary care centers for referral of high risk women for appropriate level of care. In that way, women can receive an appropriate level of service prior to admission to the hospital (perinatologist, maternal-fetal medicine specialist, etc.) and also receive inpatient services at a hospital that is capable of providing the level of care required for the pregnant woman and/or her infant.
- The cytogenetic laboratory provides prenatal and postnatal cytogenetic analysis, identifying congenital abnormalities and enabling treatment.
- Title V staff continue to interact and collaborate with Healthy Start projects within our state. NYSDOH staff meet with the Healthy Starts twice per year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. NYSDOH continued to work with all 147 designated obstetrical hospitals in the State to ensure that all pregnant women and newborns have timely access to the appropriate level of perinatal care.				X
2. All hospitals with Level I, II or III designations are required to by State Hospital Code to have perinatal affiliation/patient transfer agreements with a Regional Perinatal Center that is accessible within 2 hours.			X	X
3. NYSDOH has 11 Regional Perinatal Forums that join the expertise of the hospital provider community with the expertise of the non-hospital community to bring a public health perspective to the regionalization process.			X	X
4. Bureau of Women's Health worked with New York City Department of Health and Mental Hygiene to implement a City-wide Forum that brought together perinatal issues across New York City.			X	X
5. All Prenatal Care Assistance Programs (PCAPs) conduct risk assessment on all patients to identify any high risk factors that warrant appropriate follow-up. They have agreements with tertiary care centers for referral of high risk women.			X	X
6. The cytogenetic laboratory provides prenatal and postnatal cytogenetic analysis, identifying congenital abnormalities and enabling treatment.			X	X
7. Perinatal Forums identified a number of public health concerns that on which they plan to work, including: smoking cessation, improving prenatal care and using vital statistics data to identify areas where services are needed.			X	X
8. NYSDOH Title V staff meet with New York's Healthy Start projects at least twice per year.				X
9.				
10.				

b. Current Activities

- DOH is continuing to implement Regionalization and Perinatal Regional Forums.
- In early 2007, funding was distributed through a Request for Proposals (RFP) to improve the quality of perinatal services in New York State (NYS). The Bureau of Women's Health and the Association of Regional Perinatal Programs and Networks (ARPPN), the organization representing the Regional Perinatal Centers (RPCs) in NYS, collaborated on this initiative, with the ARPPN responsible for distributing the funds to hospitals on a competitive basis. The funded projects under this $420,000 initiative included projects to improve perinatal outcomes in obstetric hospitals across the state, such as reduction of elective deliveries prior to 39 weeks gestation, regional reporting and benchmarking using the SPDS core and NICU modules, NICU benchmarking to reduce nosocomial infections and those from percutaneously inserted central catheters, a perinatal performance improvement program, an assessment of quality of care delivered at and by the RPCs, and a Healthy Students, Healthy Communities toolkit to improve community adolescent health. Manuals, toolkits and other materials developed as a result of these projects will be provided to the Department
- Perinatal Forums identified a number of public health concerns on which they plan to work, including: smoking cessation, improving prenatal care and using data to identify areas where services are needed. Staff continue to work to address these concerns.

c. Plan for the Coming Year
No major changes are planned.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	80	82.5	85	77	78
Annual Indicator	74.7	74.9	75.4	74.6	74.6
Numerator	180870	175151	174737	174078	174078
Denominator	242030	233802	231661	233441	233441
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	79	80	81	82	82

Notes - 2007
2006 data are being used as a proxy for 2007.

a. Last Year's Accomplishments
- The Growing Up Healthy Hotline handled 6,780 phone calls in 2007 relating to prenatal care and 42 relating to pregnancy testing.
- The Comprehensive Prenatal/Perinatal Services Networks (CPPSNs) have as their objective to increase the percentage of women entering prenatal care in their first trimester. In addition to the statewide Growing Up Health Hotline, Networks have local toll-free numbers, web sites, resource directories or other mechanisms to provide pregnant women with information and referral to prenatal care. Networks also identify gaps and barriers to the service system, and in collaboration with the Consortium, work to increase accessibility and the quality of the local

perinatal service system.

- PCAP and MOMS encouraged early enrollment in prenatal care, offered presumptive eligibility, and ensured timely initiation of services.
- Public awareness campaigns and the Growing Up Healthy Hotline helped raise awareness of the need for early prenatal care.
- An important collaboration between Title V and the AIDS Institute is the Community Action for Prenatal Care (CAPC) Program. This initiative seeks to decrease negative birth outcomes, including mother-to-child HIV transmission, by engaging high risk pregnant women in early prenatal care. CAPC is closely coordinated with the Community Health Worker Programs in overlapping regions of New York City and Buffalo.
- The Community Health Worker Program is a premier enabling service. Specially trained individuals from the target communities educate pregnant women and parents about health needs and instruct/role model the appropriate use of the health care system. They provide enhanced outreach services to engage families and individuals into the system and assist them to sustain relationships with appropriate providers. Of those women who were not already in prenatal care, 96.6% were assisted to receive prenatal care within 1 month of entry to the program. Of the total number of pregnant women in CHWP, 79.2% entered prenatal care in the first trimester, 17% in second, 2.8% in third; 0.3% did not receive prenatal care and there are no data for 0.7% of the pregnant women in CHWP.
- School--based health centers provided pregnancy testing and reinforced the need for early prenatal care. Access is provided either on-site or through referral to the back-up facility. Nearly 2% of visits indicated pregnancy or contraception as a primary diagnosis.
- The Family Planning Programs made early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served. Early entry into prenatal care continues to be a high priority.
- The Bureau of Women's Health periodically conducts a statewide media campaign to increase awareness of the importance of early prenatal care. Whenever such a campaign was conducted, calls to the Hotline increased.
- Preconception care materials were developed by the Department and the American College of Obstetricians and Gynecologists, District II, as a result of the findings of the Safe Motherhood Initiative. These materials included a booklet on preconception care and an accompanying laminated card, a tri-fold pamphlet on managing obesity, encouraging physicians to consider reproductive consequences of obesity and providing advice on mitigating preconception risks for women of childbearing age. The materials will be mailed to over 16,000 physicians throughout New York State.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Growing Up Healthy Hotline handled 6,780 phone calls in 2007 relating to prenatal care and 42 relating to pregnancy testing.		X	X	X
2. The Comprehensive Prenatal/Perinatal Services Networks (CPPSNs) have as their objective to increase the percentage of women entering prenatal care in their first trimester. Community campaigns were conducted.			X	X
3. PCAP and MOMS encouraged early enrollment in prenatal care, offered presumptive eligibility, and ensured timely initiation of services.	X	X	X	X
4. Public awareness campaigns and the Growing Up Healthy Hotline helped raise awareness of the need for early prenatal care.		X	X	X
5. The Community Action for Prenatal Care (CAPC) Program engages pregnant, HIV positive women in early prenatal care.		X	X	X

6. The Community Health Worker Program is a premier enabling service. Specially trained individuals from the target communities and populations educate pregnant women and parents about the need for early prenatal care.		X	X	X
7. Of the pregnant women entering CHWP, 65.4% were already engaged in prenatal care. Of those women who were not, 95% were assisted to receive prenatal care within 1 month of entry to the program.		X		X
8. The School Health Program provided pregnancy testing and reinforced the need for early prenatal care. Access is either on-site or through referral to back-up facilities. Nearly 2% of visits indicated pregnancy or contraception as the reason for the	X	X		X
9. The Family Planning Programs make early referrals for women testing positive for pregnancy, thereby improving rates for early access to prenatal care in the populations served. Early entry into prenatal care continues to be a high priority.	X	X	X	X
10. The Safe Motherhood Initiative, collaboration between the American College of Obstetricians and Gynecologists (ACOG) and NYSDOH, recommended early entry into high-quality care to deter maternal mortality.			X	X

b. Current Activities

- The Safe Motherhood Initiative, collaboration between the American College of Obstetricians and Gynecologists (ACOG) and NYSDOH, recommended early entry into high-quality care to deter maternal mortality. The Bureau of Women's Health is currently working on implementing recommendations coming out of this initiative.
- In the State Fiscal Year 2007-2008 budget, a total of $2.1M was appropriated for perinatal home visiting. Title V staff were involved in the planning and design of the new Welcome Baby! Initiative, which is designed to ensure all pregnant women enter prenatal care in the first trimester, remain in prenatal care and receive the support they need to have healthy babies, including home visits to assess family needs and provide anticipatory guidance and referral services. The Department is currently reviewing applications received in response to its Request for Applications.
- A media campaign promoting the Prenatal Assistance Program is running from March 31, 2008 to June 30, 2008. The campaign is intended to increase use of prenatal care among low-income women by raising awareness of the availability of comprehensive care at no cost to eligible women. The campaign consists of television, radio and transit advertising spots in Albany, Binghamton, Buffalo, Plattsburgh, Elmira, Rochester, Utica, Watertown and New York City. Eligible women are directed to contact the Growing Up Health Hotline for information on where to receive services.

c. Plan for the Coming Year

- NYSDOH will be implementing a new home visiting initiative. The Department is currently reviewing applications received in response to the Welcome Baby! Universal Prenatal and Postpartum Home Visting Program Request for Applications. Applications were received from throughout the state. It is anticipated that 9 contracts will be funded. In addition, 1 training and education contract will be funded to support the development of a training curriculum for home visiting staff.
- The 2008-09 Executive Budget includes initiatives to improve birth outcomes for the close to 50 percent of births in the state that are paid for by Medicaid, because women insured by Medicaid have higher rates of infants with complicated and costly neonatal intensive care. Over a period of 4 years reimbursement methodology will be reallocated primarily for investments in ambulatory care and preventive care for Medicaid patients. It is anticipated that this process will be fully implemented in 2011-2012. As a first step the Budget proposes to invest in a new

standardized system of early identification of clinical and psycho-social risks for poor birth outcomes. The Department's leadership of the Medicaid and Public Health offices will undertake a comprehensive review, in consultation with all stakeholders, of Medicaid's prenatal care standards and reimbursement methodologies to ensure that New York State is buying the highest quality care, in the right setting, at the right price for the pregnant women we cover. Additionally, nurse practitioners who previously could only bill Medicaid for primary care services will now be able to bill in all specialties, including mental health; and, licensed clinical social workers will be reimbursed for services for children, adolescents and pregnant women.

- The transfer of the Adolescent Pregnancy Prevention and Services program to the Department of Health will allow for closer coordination of services for pregnant adolescents in communities. Due to the role of the community council within each of the 26 funded projects, an extensive network is available in each community to identify pregnant adolescents and assure that they are connected with prenatal care in the first trimester.
- The Welcome Baby! home visiting program will outreach to organizations serving women of childbearing age to identify pregnant women, particularly those not engaged in prenatal care. Home visits will be provided to screen women for eligibility for comprehensive home visiting programs, provide basic health education, and to make referrals to needed services. Families in need will have access to more intensive sustained home visiting services, where available.

D. State Performance Measures

State Performance Measure 1: *Percent of Live Births Resulting from Unintended Pregnancies*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				32.8	32.7
Annual Indicator	36.3	36.3	35.8	33.4	33.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	31	31	30.5	30	29.5

Notes - 2007
2006 data are being used as a proxy for 2007. Numerator and denominator data are not available. Data are from the NYS PRAMS survey for areas in NYS outside of NYC.

Notes - 2005
Numerator and denominator data are not available. Data are from the NYS Prams Survey for areas in New York Sate outside of NYC.

a. Last Year's Accomplishments

- The Family Planning Program continued to increase access to services through the Family Planning Benefits Program. Four Regional coordinators continue to provide training and outreach. This program provides family planning services to individuals under 200% of poverty who meet eligibility requirements. Eligibility does not depend on previous pregnancy or previous Medicaid status, and provides a full range of contraceptive services and reproductive health care. As a result of extensive collaboration, the terms of the 1115 Medicaid Waiver were renewed. All services under the FPBP now require appropriate ICD-9 coding, and some enhanced services were approved as follow up to a family planning visit. In addition, NYS authorized funding to cover visits for the treatment of certain sexually transmitted infections that are a follow up to a family planning visit. In 2007, over 26,000 clients were enrolled in the Family Planning Benefits

Program.

- The Family Planning Program continued to provide access to reproductive health care through the Family Planning Extension Program. This program provides family planning benefits to eligible women for 24 months after a pregnancy ends. In 2007, 13,080 women received family planning services through the Family Planning Extension program. Family Planning Programs provided over 7,786 community education sessions, reaching approximately 102,224 individuals. In addition to education, the program provided comprehensive reproductive health care, including screening for breast and cervical cancer, STD screening and treatment, and HIV counseling and testing.
- The Community Health Worker Program provided family planning information to all women of childbearing age and referred clients to family planning services.

They then follow-up to see that services were received.

- The Community-Based Adolescent Pregnancy Prevention Program's worked to reduce teen pregnancies in the highest risk zip codes across New York State. C-BAPPP promoted abstinence and the delay of sexual activity among teens; encouraged educational, recreational and vocational opportunities as alternatives to sexual activity; taught assertiveness skills; and promoted access to family planning and comprehensive reproductive health services.
- School--based health centers provided risk assessment, anticipatory guidance and health education for sexual activity as part of the initial assessment and annual comprehensive physical examination. Pregnancy testing is done, where indicated. Students have access to family planning services, either onsite or by referral. Students are also provided access to prenatal services either on site or through referral. Students are referred early for prenatal services; practitioners co-manage the student's prenatal care. School-based health centers provide services to approximately 34,000 female students ages 15-19, annually.
- The Comprehensive Prenatal-Perinatal Services Networks implemented several activities related to decreasing pregnancies through provision of family planning information and education on the importance of inter-conceptional care. Some Networks provide structured, in-school educational programs addressing reproductive health and pregnancy care. One Network developed a peer-mentoring program to encourage and model healthy behaviors in adolescents. Others developed teen pregnancy coalitions to address local issues related to adolescent pregnancies.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Family Planning Benefits Program provided services to individuals under 200% FPL who meet eligibility requirements. In 2007, over 26,000 clients enrolled in the Family Planning Benefits Program.	X	X	X	X
2. The Family Planning Extension Program provides benefits to eligible women for 24 months after a pregnancy ends. In 2007, 13,080 women received family planning services through the Program.	X	X	X	X
3. Family Planning Programs provided over 7,786 community education sessions, reaching approximately 102,224 individuals.		X	X	X
4. Family Planning Programs provided comprehensive reproductive health care, including screening for breast and cervical cancer, STD screening and treatment, and HIV counseling and testing.			X	X
5. The Community Health Worker Program provided family planning information to all women of childbearing age and referred clients to family planning services.		X		X
6. The Community-Based Adolescent Pregnancy Prevention		X	X	X

Program's worked to reduce teen pregnancies in the highest risk zip codes across New York State.				
7. SBHCs provided risk assessment, anticipatory guidance and health education for sexual activity as part of the initial assessment and annual physical examination. Pregnancy testing and referrals for prenatal services are made, where indicated.	X	X		X
8. The Comprehensive Prenatal/Perinatal Services Networks implemented several activities related to decreasing pregnancies through provision of family planning information and education on the importance of inter-conceptional care.			X	X
9. NYSDOH continued to fund 37 Abstinence Education and Promotion programs to provide abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 10- to 19-year-olds through 9/30/07.			X	X
10. A law requiring all hospitals to promptly provide information on emergency contraception (EC) to survivors of sexual assault, and provide EC if necessary, has been implemented.			X	X

b. Current Activities

Some Networks are also the lead agencies for Community-Based Adolescent Pregnancy Prevention Programs.

- NYSDOH continued to fund 37 Abstinence Education and Promotion Programs to provide abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 10- to 19-year-olds through September 30, 2007.
- An important component of PCAP is to provide family planning education and services, ensuring all enrolled postpartum women have identified a method of family planning the will utilize. The concept of spacing of pregnancies and provide family planning services and referrals may impact future pregnancies of teens in PCAP.
- A law requiring all hospitals to promptly provide information on emergency contraception (EC) to survivors of sexual assault, and provide EC if necessary, /2008/has been//2008// implemented. An EC brochure was drafted and made available in seven languages. It is also available on the NYSDOH website. Hospitals and other sites are directly compensated for forensic exams.
- School-based health centers provide risk assessment, anticipatory guidance and education as part of the initial assessment and annual comprehensive physical examinations. Pregnancy testing is done and students are provided access to prenatal services, when indicated, either by the back up facility or through referral to another care provider.

c. Plan for the Coming Year

New York is redirecting state funds from the discontinued Abstinence Education and Promotion Initiative to the Community Based Adolescent Pregnancy Prevention Program in order to expand comprehensive sexuality education in schools and other community settings to provide teens with medically accurate information and life skills to equip them with the necessary tools that they need to make the crucial healthy life choices needed for a healthy adulthood.

The transfer of the Adolescent Pregnancy and Parenting Services (APPS) program from the Office of Children and Family Services will allow for greater coordination of services for pregnant adolescents through 21 years of age. Twenty-six programs are funded through community based organizations across the state providing the following services: counseling; basic needs; academic education; health services; employment services; recreational services; parent education; housing services; child care; and, services for infants and children.

State Performance Measure 2: *Hospitalilzation Rate for Asthma in Children 1 to Age 14*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				245	235
Annual Indicator	401.5	384.0	335.9	319.2	319.2
Numerator	14119	13588	11729	11716	11716
Denominator	3516854	3538603	3492321	3670552	3670552
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	235	235	230	230	230

Notes - 2007
2006 are being used as a proxy for 2007.

a. Last Year's Accomplishments

- The Asthma Coordinator continued to play a pivotal role in coordinating asthma prevention and control efforts across the agency. Title V and the Asthma Coordinator are working with the Office of Health Insurance Programs (which includes the Child Health Plus and Medicaid Programs), The Center for Environmental Health, the Division of Chronic Disease Prevention and Adult Health, the State Education Department, the New York City Department of Health and Mental Health (which has its own major asthma initiative), the Pediatric Pulmonary Center, the Public Health Information Group. NYSDOH has two CDC grants totaling over $3.0 to implement and enhance statewide asthma initiatives. The State budget includes over $1.5 M for asthma initiatives, as well. Implementation of the NYSAP requires operationalizing the Asthma Partnership of New York, enduring public/private collaboration with the New York City Department of Health and Mental Hygiene, the CDC and key statewide and national stakeholders. Guided by a common vision and shared goals detailed in the NYSAP, the Asthma Partnership of New York (APNY) has been established and is responsible for the implementation and ongoing monitoring of the NYSAP.
- A statewide asthma plan that was first completed in 2000 was updated in 2006. The goals are for: seamless, evidence-based, patient and family friendly asthma care for all New Yorkers with asthma; elimination of disparities in asthma diagnosis, treatment and outcomes; establishing "asthma friendly" communities in New York State; increased knowledge and understanding of effective asthma treatment and management by policy-makers, health care providers and consumers; and a statewide public/private collaboration to shape, implement and monitor New York's action, which will improve asthma outcomes.
- The results of the National Asthma Survey for New York State were published and disseminated. Asthma hospitalization rates were updated by various demographic characteristics, and made available on the Department's intranet.
- Emergency Department surveillance became effective in 2005. Asthma Program staff are now checking the validity and comparability of these data with medical charts from facilities with high volumes.
- The public website includes information on asthma interventions, asthma care and asthma-related patient materials.
- The Occupational Lung Disease Registry continued to collect information about work-related asthma.
- User-friendly asthma treatment guidelines continue to be distributed across the state. The NYS Consensus Asthma Guideline Expert Panel finalized the Clinical Guidelines for the Diagnosis, Evaluation, and Management of Adults and Children with Asthma in 2005. Based on the new EPR-3 recommendations published in August of 2007, this guideline is currently being updated.

• NYSDOH has been measuring asthma care through HEDIS since 1997. Rates of performance increased across all insurers and all age groups. HMOs with sub-standard performance in these areas are required to develop action plans for improvement.
• Asthma Model Benefit Package: An assessment of health insurance benefit coverage for asthma care was conducted, including how the benefit packages differ and in what ways they could be aligned to better support good asthma care. Findings were shared with a subcommittee of representatives from the NYS Consensus Asthma Guideline Expert Panel and the Asthma Partnership of New York during a conference call in August 2007. Recommendations for changes in the current benefit package resulted.
• The NYSDOH continued to award funds to nine regional asthma coalitions across the State to improve the diagnosis, treatment and prevention of childhood asthma, and provide care coordination services to asthmatic children in an effort to reduce asthma-related morbidity and mortality.
• School Nurse Asthma Management Program: The NYSDOH Asthma Program has partnered with the National Association of School Nurses (NASN), the School Nurse Asthma Management Program (SNAMP) and the New York State Regional Asthma Coalitions to provide comprehensive asthma education and resources to school nurses in New York State.
• SBHCs assess students for asthma and develop Asthma Action Plans for those who are diagnosed. SBHCs work with other community providers, when indicated, to coordinate education and care management for affected students.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Asthma Coordinator continued to play a pivotal role in coordinating asthma prevention and control efforts across the agency.				X
2. DOH continues to make asthma information available on the Department's intranet, the public website, and also by hardcopy. The public website includes information on asthma interventions, asthma care and asthma-related patient materials.		X	X	X
3. The Occupational Lung Disease Registry collects information about work-related asthma.			X	X
4. Medicaid fee-for-service and managed care data have been used to generate age- and county-specific rates. These data were also used to generate asthma-related costs.			X	X
5. User-friendly asthma treatment guidelines are available through the Asthma Program. The finalized Clinical Guidelines build on the NAEPP/NIH guidelines.			X	X
6. An assessment of public (Medicaid, Family Health Plus and Child Health Plus) health insurance benefit coverage for asthma care was conducted, gaps identified and recommendations were made to close those gaps.			X	X
7. The NYSDOH continued to award funds to 9 regional asthma coalitions across the State in an effort to reduce asthma-related morbidity and mortality.		X	X	X
8. The School Nurse Asthma Management Program is a school-based program to improve asthma care and management in the school setting.	X	X	X	X
9. Over 900 school nurses participated in a project to improve the health and learning potential of students with asthma.	X	X	X	X
10. School-based health centers develop Asthma Action Plans for students diagnosed with asthma and when indicated, work	X	X		X

with other community providers to coordinate care.				

b. Current Activities

- Based on the School Environment Assessment Project, the NYS Asthma Program is working with schools to identify barriers to implementation of the Indoor Air Quality Management Program.
- In 2005, legislation required all NYS public and private schools to procure and use only environmentally-sensitive ("green") cleaning and maintenance products.
- A SBHC Asthma Learning Collaborative is being conducted to improve asthma care in five NYC SBHCs in East and Central Harlem.
- The Erie County HNP is collaborating with the Asthma Program and 4 health plans in Western NY to integrate in-home environmental management for high risk patients.
- Commissioners of the Departments of Health and Environmental Conservation issue joint press releases when ozone and fine particulate pollution levels are of concern.
- 33 CHCs, primary care providers, SBHCs, day care centers and school health services are participating in an ongoing Quality Improvement Project based on the principles of the Chronic Care Model.
- NYS Asthma Program, OHIP and the NYS Asthma Guideline Expert Panel developed a clinical decision support tool for primary care providers based on the NAEPP EPR-3 recommendations. In addition, an asthma model benefits package that reflects good asthma care has been developed to educate public insurers and educate payers/purchasers on current recommendations.
- In 2007, legislation was passed to provide reimbursement for asthma self management education by Certified Asthma Educator.

c. Plan for the Coming Year

In addition to the activities listed above, a targeted asthma and influenza immunization campaign will be conducted targeted all children who receive their care in New York's 227 School Based health Centers.

State Performance Measure 4: *Teenage Pregnancy Rate for Girls Ages 15-17*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				35	34
Annual Indicator	38.2	37.5	36.5	36.3	36.3
Numerator	14276	14283	14256	14444	14444
Denominator	373439	381221	390618	398091	398091
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	34	33	33	32	32

Notes - 2007

2006 data are being used as a proxy for 2007.

a. Last Year's Accomplishments

- MCHSBG funds support 53 local Family Planning Programs. These programs serve low-income, uninsured women, or approximately one third of those estimated in need, and more than one quarter of whom were under the age of 20. The program strives to ensure that each pregnancy is intended. Family Planning Programs provided community education and public information services, comprehensive medical exams, a full range of contraceptive services, and special counseling to teens.
- Community-Based Adolescent Pregnancy Prevention Programs (CBAPP) employed

numerous strategies including school-based comprehensive reproductive health education, peer counseling, parental education, and facilitating access to reproductive health services in 234 high risk zip codes to effectively educate youth, dispel common myths about sexuality, encourage discussions about abstinence and responsible sexual behavior, and provide accurate information about how and where to obtain primary and preventive health services. CBAPPP worked with schools and parents to increase communication skills and sexual literacy.

- 37 Abstinence Education and Promotion Projects provided abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 10- to 19-year-olds. Funding for this program was discontinued at the end of September, 2007,and funds will be used to support other adolescent pregnant prevention programs.
- The Networks implemented several activities related to decreasing adolescent pregnancies through provision of family planning information and education on the importance of intra-conceptional care. Some Networks have accessed schools to provide structured educational programs addressing reproductive health and pregnancy care. One Network has a peer mentoring program to encourage and model healthy behaviors in adolescents. Others have developed groups such as teen pregnancy coalitions to address local issues related to adolescent pregnancies. Some are lead agencies for the Adolescent Pregnancy Prevention Program.
- The Comprehensive Prenatal/Perinatal Services Networks provided conferences on adolescent pregnancy prevention for their communities. Each Network takes a localized approach to the issue.
- School-based health centers provided risk assessment as part of the initial assessment and as part of an annual comprehensive physical examination, provided consultation and health education, anticipatory guidance, family planning services (either directly or by referral), pregnancy testing, prenatal care (either directly, by co-managing care, or by referral), and follow-up consultation and patient education.
- The Community Health Worker Program educated women of childbearing age regarding family planning, referred to family planning services and followed up to determine whether appointments are kept and services are received.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCHSBG funds support 53 local Family Planning Programs. These programs serve low-income, uninsured women, or approximately one third of those estimated in need, and more than one-quarter of whom were under the age of 20.	X	X	X	X
2. Community-Based Adolescent Pregnancy Prevention Program provided services in 234 high risk zip codes.			X	X
3. 37 Abstinence Education and Promotion contractors provide abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual activity in 10 to 19-year-olds, through 9/30/07.			X	X
4. The Networks implement several activities related to decreasing adolescent pregnancies through provision of family planning information and education on the importance of intra-conceptional care.		X	X	X
5. The Comprehensive Prenatal/Perinatal Services Networks provided conferences on adolescent pregnancy prevention for their communities			X	X
6. SBHCs provided risk assessment as part of the initial assessment and annual physicals, provided consultation and health education, f/u consultation, pregnancy testing, and, either	X	X		X

directly or by referral, family planning services, prenatal care.				
7. The Community Health Worker Program educated women of childbearing age regarding family planning, referred to family planning services and followed up to determine whether appointments are kept and services are received.		X		
8. The "Growing Up Healthy" Hotline links women (including adolescents) with prenatal, nutrition, family planning, psychosocial and supportive services, which contributed to healthy pregnancies and improved birth weights.			X	X
9. ACT for Youth utilizes an assets-based approach to reduce risk-taking behavior among youth.		X	X	X
10. The 76 Rape Crisis Centers work to reduce the incidence of rape and sexual assault, as well as to ensure effective, compassionate treatment of victims.	X	X	X	X

b. Current Activities

- The "Growing Up Healthy" Hotline links women (including adolescents) with prenatal, nutrition, family planning, psychosocial and supportive services, which contributed to healthy pregnancies and improved birth weights.
- Teens may be eligible for PCAP/MOMS and WIC.
- ACT for Youth utilizes an assets-based approach to reduce risk-taking behavior among youth.
- The Department continued to work with other agencies, including the Office of Children and Family Services and the State Education Department.
- The 76 Rape Crisis Centers work to reduce the incidence of rape and sexual assault, as well as to ensure effective, compassionate treatment of victims to reduce debilitating consequences once an assault has occurred. In addition to ensuring effective, compassionate treatment of victims to reduce debilitating consequences once an assault has occurred, the rape crisis centers also provide comprehensive primary prevention education programs to the community they serve.
- Please refer to materials presented under State Performance Measure 01 on unintended pregnancy.

c. Plan for the Coming Year

Beginning October 1, 2007, New York is redirecting state funds to the Community Based Adolescent Pregnancy Prevention Program in order to expand comprehensive sexuality education in schools and other community settings to provide teens with medically accurate information and life skills to equip them with the necessary tools that they need to make the crucial healthy life choices needed for a healthy adulthood.

The transfer of the Adolescent Pregnancy and Parenting Services (APPS) program from the Office of Children and Family Services will allow for greater coordination of services for pregnant adolescents through 21 years of age. Twenty-six programs are funded through community based organizations across the state providing the following services: counseling; basic needs; academic education; health services; employment services; recreational services; parent education; housing services; child care; and, services for infants and children.

State Performance Measure 6: *Percent of infants who are put down on their backs to sleep.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				82	84

Annual Indicator	69	69.5	67.2	71.9	71.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	84	85	85	85	86

Notes - 2007
2006 data are being used as a proxy for 2007. Data are from the NYS PRAMS Survey which includes women residing in NYS outside of NYC.

Notes - 2006
Data are from NYS PRAMS Survey which includes women residing in NYS outside of NYC.

Notes - 2005
Numerator and denominator data are not availalbe (survey data), Data are from the PRAMS Survey which includes women from areas in NYS outside of NYC.

a. Last Year's Accomplishments

- Again, there was a decline in the number of SIDS deaths, /2008/however, the number of mothers reporting putting their babies to sleep on their backs on the PRAMS survey declined, which may indicate a need to renew the "Back to Sleep" Campaigns. In 1999-2001, the Department produced T-shirts imprinted on the front and back with, "Put me on my back to sleep." These T-shirts and a flyer on SIDS prevention were distributed thorough all hospitals in the State.
- SIDS Prevention Information Cards (the same cards that were made available with the T-shirt) are still available through our health publications catalog and on the public website.
- SIDS Prevention Posters were developed after staff learned of the lack of awareness of the "Back to Sleep" message in the child care community. We continue to distribute posters to childcare providers in the state as a reminder to place babies on their backs to sleep. Other SIDS prevention messages were included, too.
- Statewide training efforts continue. Police, fire fighters, emergency medical personnel and public health nurses are educated on appropriate responses to SIDS. The Department oversees notification of infant deaths by funeral directors, coroners and medical examiners. The Center for Sudden Infant Death at SUNY Stony Brook and its satellites provide training and family support services. For families that have experienced any infant death in the last year, they provide a 1-800 "warm line" for support, information and referral to self-help groups and other mental health services. The Center also arranges a home visit by a public health nurse. Newsletters are sent on a regular basis, and are a very popular item. The Center also released health education materials about the dangers of placing infants to sleep in adult beds.
- A special SIDS prevention project was initiated among the St. Regis Mohawks in 2005. These efforts continued in 2007.
- In May 2002, a State law was passed amending the autopsy provisions of the Public Health Law and requiring standardized protocols for the performance of autopsies in cases of sudden, unanticipated death in infants under the age of one year. Protocols were developed. This law is now fully implemented.
- "Welcome to Parenthood" contains messages concerning back-to-sleep and overlaying dangers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Again, there was a decline in the number of SIDS deaths.			X	X
2. SIDS Prevention Posters were developed after staff learned of the lack of awareness of the “Back to Sleep” message in the child care community.			X	X
3. Statewide training efforts continue. Police, fire fighters, emergency medical personnel and public health nurses are educated on appropriate responses to SIDS.			X	X
4. The Department oversees notification of infant deaths by funeral directors, coroners and medical examiners.			X	X
5. The Center for Sudden Infant Death at SUNY Stony Brook and its satellites provide training and family support services.		X	X	X
6. For families that have experienced any infant death in the last year, they provide a 1-800 “warm line” for support, information and referral to self-help groups and other mental health services. The Center also arranges a home visit by a PHN.		X	X	X
7. Newsletters are sent on a regular basis, and are a very popular item. The Center also released health education materials about the dangers of placing infants to sleep in adult beds.			X	X
8. A special SIDS prevention project was implemented among the St. Regis Mohawks.			X	X
9. “Welcome to Parenthood” contains information concerning back-to-sleep and overlaying dangers.			X	X
10.				

b. Current Activities
No major changes were implemented.

c. Plan for the Coming Year
NYSDOH will revisit current activities in light of the downward trend in PRAMS data that seems to indicate that fewer new moms are placing their babies on their backs to sleep.

State Performance Measure 7: *Hospitalizations for Self-Inflicted Injuries for 15-19 Year Olds*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				0.1	0.1
Annual Indicator	0.1	0.1	0.1	0.1	0.1
Numerator	1257	1421	1291	1320	1320
Denominator	1279454	1297818	1318372	1289480	1289480
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1

Notes - 2007
2006 data are being used as a proxy for 2007.

a. Last Year's Accomplishments
- See National Performance Measure 16. This measure was selected because rates of suicide attempts are higher than rates of completion would indicate.
- All school-based health centers provided psychosocial assessment as part of the initial

assessment and visit, the annual comprehensive physical examination and at follow up visits, when indicated. Students and families were offered individualized education regarding safety issues and abuse, and when indicated, mental health services were made available. Potential abuse and neglect cases were reported. Staff followed-up on all referrals for mental health services and behavioral issues.

- Over 180,000 students have access to mental health services through school-based health centers. 59% of school-based health center sites in New York State provided onsite mental health services, and 41% provided mental health services through referral.
- Through community collaborations, the ACT for Youth Initiative has developed: youth forums on violence, abuse and risky sexual behaviors; peer education for violence prevention; conflict resolution training to train peer mediators; and mentoring programs. Janis Whitlock, PhD, MPH, of the ACT for Youth Center of Excellence provided training statewide to adolescent health providers on self-injurious behavior in adolescents.
- Through community collaborations, the ACT for Youth Initiative has developed: youth forums on violence, abuse and risky sexual behaviors; peer education for violence prevention; conflict resolution training to train peer mediators; and mentoring programs.
- The Community-Based Adolescent Pregnancy Prevention Program employs a youth development/youth empowerment approach to build resiliency and developmental assets.
- The Emergency Medical Services for Children Advisory Committee developed a White Paper with recommendations for NYSDOH Commissioner for the standardization and regionalization of pediatric hospital care. This White Paper provided evidence that the standardization and regionalization of pediatric care in NYS will improve health outcomes for children.
- NYSDOH continues to collaborate with the Office of Mental Health and the Office of Alcohol and Substance Abuse Services.
- The Early Childhood Comprehensive Systems Plan seeks to bolster early relationships and positive development, with the end result of higher functioning youth, adults and families. Parental support is a key issue.
- The Advisory Council hosted speakers from Mary Imogene Bassett Hospital and Johns Hopkins University who presented their project on improving communication skills for primary care providers. This model appears to improve patient outcomes while making effective use of limited practitioner time. Final data from the project are pending.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. See National Performance Measure 16. This measure was selected because rates of suicide attempts are higher than rates of completion would indicate.			X	X
2. SBHCs provided psychosocial assessment as part of the initial assessment, annual physicals and at follow up visits, when indicated. Individualized education re safety issues and abuse, and mental health services were made available as indicated.	X	X		X
3. Over 180,000 students have access to mental health services through school-based health centers.	X	X		X
4. Through community collaborations, the ACT for Youth Initiative has developed: youth forums on violence, abuse and risky sexual behaviors; peer education for violence prevention; conflict resolution training to train peer mediators.		X	X	X
5. The Community-Based Adolescent Pregnancy Prevention Program employs a youth development/youth empowerment approach.			X	X
6. Emergency Medical Services for Children Advisory Committee			X	X

developed a White Paper with recommendations for NYSDOH Commissioner for the standardization and regionalization of pediatric hospital care.				
7. The NYS ECCS Plan provides strategies for improved parental support in early childhood, which should result in more intact, adaptable families and youth.			X	X
8. NYSDOH continues to collaborate with the Office of Mental Health and the Office of Alcohol and Substance Abuse Services.			X	X
9. The Advisory Council examined models for incorporation of mental health interventions into primary care.	X			X
10.				

b. Current Activities

- Bureau of Child and Adolescent Health continued working with the Office of Mental Health and other partners to identify key elements of a statewide suicide prevention plan.
- School-Based Health Centers continue to assess students for suicide risk, and provide enhanced mental health services, either directly or by referral.
- Youth development continues to be a focus of all youth-related activities.
- The Council is discussing various models for better incorporating mental health interventions into primary care.

c. Plan for the Coming Year

No major changes are planned.

State Performance Measure 8: *Percent of High School Students who had five or more drinks of alcohol in a row at least once in the Last Month*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				19	18
Annual Indicator	25.3	25.3	23.9	23.9	24.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	18	18	18	18	18

Notes - 2007

Numerator and Denominator data are not available (2007 YRBS survey data)

Notes - 2006

2006 data are from the 2005 YRBS (biannual) survey. There are no numerator or denominator data available from this survey.

Notes - 2005

Data are from the Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data).

a. Last Year's Accomplishments

- DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Services (OASAS) on substance abuse and alcohol-related prevention policy. Beginning in 1999, OASAS involved multiple human service agencies at the county level in

identifying alcohol and substance abuse risk and protective factors, and in strengthening and expanding local partnerships for alcohol and substance abuse prevention. Fifteen (15) counties were funded for three years to develop and implement countywide, prevention- and results-focused work plans. These work plans identified, re-directed, and leveraged state and local resources for a comprehensive, multi-system approach to alcohol and substance abuse prevention at the local level.

- OASAS implemented a new statewide prevention campaign entitled, "Underage Drinking: Not a Minor Problem." Title V programs promoted the campaign to health care providers.
- The focus of ACT for Youth, (Assets Coming Together for Youth) is to empower youth and engage them in community strategies to prevent abuse, violence and risky sexual activities, all of which are associated with low self-esteem; poor decision making related to sexual behavior, alcohol and substance use and abuse; poor nutrition and eating disorders. Collaborations for Community Change seek to engage all youth in their communities in order to reach the most vulnerable populations (substance abusing/using, those in foster care and group homes, homeless and runaway, orphaned, out-of-school, incarcerated, HIV affected/ infected, migrant, parenting, with disabilities, with different sexual preferences, in special education programs, and Black/African American, Hispanic/Latino, Asian/Pacific Islander and Native American).
- Over half of the Lesbian, Gay, Bi-Sexual, Trans-gendered Health Initiative contractors targeted issues related to alcohol, substance abuse and self-inflicted injury.
- PCAP/MOMS clients are assessed for alcohol and substance abuse issues; referrals are made accordingly.
- The initial school-based health center assessment, and subsequent annual comprehensive physical examination, include questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral is available for consultation/intervention where onsite services are not provided.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Services (OASAS) on substance abuse and alcohol-related prevention policy.			X	X
2. OASAS implemented a statewide prevention campaign entitled, “Underage Drinking: Not a Minor Problem.” Title V programs promoted the campaign to health care providers.			X	X
3. The focus of ACT for Youth, (Assets Coming Together for Youth) is to empower youth and to prevent abuse, violence and risky sexual activities, all of which are associated with low self-esteem; poor decisions; alcohol and substance use.			X	X
4. Community Development Partnerships target the most vulnerable youth populations.			X	X
5. Over half of the Lesbian, Gay, Bi-Sexual, Trans-gendered Health Initiative contractors targeted issues related to alcohol, substance abuse and self-inflicted injury.	X	X	X	X
6. PCAP/MOMS clients are assessed for alcohol and substance abuse issues; referrals are made accordingly.	X	X	X	X
7. PCAP/MOMS clients are assessed for alcohol and substance abuse issues; referrals are made accordingly.	X	X	X	X
8.				
9.				
10.				

b. Current Activities

- No major changes.
- All Title V related programs continue focus on youth empowerment/ youth development.

c. Plan for the Coming Year

All Title V related programs will continue to employ a youth empowerment/ youth development focus.

The Bureau of Women's Health, through interagency collaboration and coordination with the Fetal Alcohol Spectrum Disorders (FASD) Interagency Work Group, is working to advance the effective prevention and treatment of FASD in New York State. The member agencies include: Council on Children and Families (CCF), Developmental Disabilities Planning Council (DDPC), Department of Health (DOH), Department of Probation and Correctional Alternatives (DPCA), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Court Administration (OCA), Office of Children and Family Services (OCFS), Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), and State Education Department (SED). Each participating agency is reviewing how its service delivery system can positively impact the goals of eliminating alcohol use during pregnancy and improving the lives of New Yorkers affected by prenatal alcohol exposure.

State Performance Measure 9: *Percent of High School Students Who Smoked Cigarettes in the Last Month*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				5	5
Annual Indicator	20.2	20.2	16.2	16.2	13.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5	5	5	5	4

Notes - 2007

Numerator and Denominator data not available (2007 YRBS survey data).

Notes - 2006

Data are from the Youth Risk Behavior Survey. Numerator and denominator data are not available (survey data). 2005 data are being used as a proxy for 2006.

Notes - 2005

Data are from the 2005 YRBS. Numerator and denominator data are not available (survey data).

a. Last Year's Accomplishments

- These data are tracked via the Youth Risk Behavior Survey (YRBS).
- Beginning June 3, 2008 New York State has the highest State cigarette excise taxes in the nation. Raising the price of cigarettes discourages youth smoking.
- Enforcement of a tough indoor air law continued, banning smoking in public places, including restaurants and bars.
- The Tobacco Control Program continues to fund Youth Action Partners to work with youth to become activists in the movement to change community norms related to tobacco use. These 46 programs engage middle and high school youth in activities aimed at de-glamorizing

and de-normalizing tobacco use in their communities.

- The State also funds local 29 Tobacco Control Community Partnerships in every county of the state. These partnerships work to change the community environment to support the tobacco-free norm. Partnerships engage local stakeholders, educate community leaders and the public, and mobilize the community to strengthen tobacco-related policies to restrict the use and availability of tobacco products and tobacco product promotion and limit opportunities for exposure to second hand smoke.
- The Tobacco Control Program funded contractors work with local leaders to educate them on the public health benefits of passing local ordinances on smoking in public places, removing tobacco products from the reach of youth, and to reduce tobacco advertising in areas frequented by youth.
- The Tobacco Control Program began in 2001 planning for inclusion of tobacco education in school-based health centers. Several centers were funded to provide tobacco education and cessation.
- The initial assessment in school-based health centers, and annual comprehensive examination, includes questions about tobacco and alcohol use. Students are counseled and educated accordingly. Referral for smoking cessation is available. The SBHC Program funded 11 Tobacco Cessation Centers.
- PCAP, MOMS, WIC and the Community Health Worker Program assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.
- Comprehensive Prenatal/Perinatal Services Networks create awareness of the dangers of smoking, particularly in pregnancy.
- The Tobacco Control Program maintained 46 youth action empowerment "Reality Check" contracts.
- The Tobacco Program participated in the Oral Health Coalition and formulation of the Oral Health Plan.
- New York makes smoking cessation assistance available through a toll-free hotline and purchase of smoking cessation products is available through Medicaid.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. These data are tracked via the Youth Risk Behavior Survey (YRBS). NYSODH collaborates with NYS Education Department on YRBS.			X	X
2. As of June 3, 2008 New York State has the highest state cigarette excise taxes in the nation. Raising the price of cigarettes discourages smoking.			X	X
3. Enforcement of a tough indoor air law continued, banning smoking in public places, including restaurants and bars.			X	X
4. The Tobacco Control Program continued to engage youth in unannounced compliance checks on retail sales of tobacco to minors.			X	X
5. New York state law requires that all tobacco products be kept behind the counter.			X	X
6. The Tobacco Control Program continued to fund Youth Partnerships for Health (YPH) to help change community norms regarding tobacco use.			X	X
7. NYS funds local Tobacco Control Coalitions in every county of the state to mobilize communities in counter-advertising activities such as banning billboards that promote tobacco near schools and playgrounds.			X	X
8. NY makes smoking cessation assistance available through a		X	X	X

toll-free hotline and web site, which both offer free nicotine replacement therapy to eligible NYS smokers (most are eligible), and smoking cessation products are available through Medicaid.				
9. PCAP, MOMS, WIC and the Community Health Worker Program assess prenatal clients for tobacco use and refer to or provide smoking cessation and other counseling/health teaching.	X	X	X	X
10. Comprehensive Prenatal-Perinatal Services Networks create awareness of the dangers of smoking, particularly in pregnancy.			X	X

b. Current Activities
NYSDOH continued to implement successful programs as outlined above.

c. Plan for the Coming Year
Title V will continue to collaborate with Division of Chronic Disease Prevention and Adult Health, who is the DOH lead for smoking related public health programming.

State Performance Measure 10: *Percent of children in the birth year cohort who were screened for high blood lead before the age of two.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				87	87
Annual Indicator	68	63	63	69.5	69.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	80	81	82	83	83

Notes - 2007
Data are from the NYS Lead Tracking System, based on the 2004 birth cohort ,with testing through 2007.

Notes - 2006
Data are based on the 2004 birth cohort with testing through 2007.

Notes - 2005
Data are based on the 2002 birth cohort with testing through 2005..

a. Last Year's Accomplishments
- 2006 and 2007 screening rates of children born in 2004 in NYS showed that 69.5% received at least one blood lead screening test by age 24 months, and 82.8% by age 36 months. Approximately 86% of low income children in Medicaid Managed Care plans in 2005 were screened at least once for lead by age 2.
- NYS has implemented a plan to eliminate childhood lead poisoning by 2010, consistent with Federal guidance, with improving blood lead screening as one of the primary goals. Trend data show improvements in the proportion of children receiving blood lead screening tests by age 24 months and by age 36 months over the last few years.
- The Department of Health secured new funding totaling $3 million to support a new primary prevention program to identify and reduce lead hazards in children's environments before they become lead-poisoned. Seven target counties and NYC, which account for 80% of cases of childhood lead poisoning, have been identified as high incidence areas.
- The Childhood Lead Poisoning Prevention Program coordinates a comprehensive public

health approach to prevent and eliminate the problem of childhood lead poisoning in NYS. New York's comprehensive public health approach addresses all aspects of lead poisoning prevention, including: education to families, health care providers, professionals, and the public; surveillance, data analysis, and laboratory reporting quality assurance; promotion and assurance of childhood lead screening; assurance of timely, comprehensive medical and environmental management for children with lead poisoning; policy and program activities to advance primary prevention of lead poisoning to reduce exposure before children become lead poisoned; and response to emerging lead-related public health issues, such as lead poisoning among refugee children and recalls of toys and other consumer products contaminated with lead.

- Because NYS has more pre-1950's housing than any other state, New York has a universal screening policy. Health care providers are required to screen children for high blood lead at ages 1 and 2, and up to age 6 if a risk is identified.
- The Childhood Lead Poisoning Prevention Program has contracts with 57 local health departments and New York City to provide prevention programs and provide care coordination.
- In 2007, a competitive application and awards process was completed to fund three Regional Lead Resource Centers. The Centers will provide outreach, education, consultation and technical assistance to health care providers and local health departments on lead screening and management for children and pregnant women. In this new funding cycle, increased emphasis was placed on effective outreach and education to improve lead screening practices.
- Letters were distributed to WIC providers and 24,000 health care providers informing them of the added fields on the WIC Medical Referral Form and reinforcing the importance of lead screening in this high-risk population.
- In collaboration with the NYS Office of Children and Family Services, the Department distributed a letter to all licensed NYS child care providers reinforcing the importance of lead screening and NYS lead screening requirements; requirements specific to child care health records; and resources available, to assist child care providers. The letter was distributed to 20,000 child care providers located in upstate NY, including: child care centers, group family day care and family providers.
- Local health departments and State Health Department District Offices provide environmental assessments and lead hazard control services.
- Wadsworth Center operates a public health lead screening laboratory where blood from children throughout the state is tested for lead levels.
- Promoting an understanding of the need for lead screening and the importance of primary health care is a priority of the Community Health Worker Program. The CHWP will continue to strive to improve percent of children screened.
- In June, 2007, a two-day meeting was held for local health department nursing and environmental health staff. The meeting provided updates on current research and emerging trends related to lead poisoning prevention in children and pregnant women and primary prevention.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A plan to eliminate childhood lead poisoning by 2010 has been formulated and is being implemented.	X	X	X	X
2. NY is a universal screening state. The overall screening rate for by age 2 is approximately 69.5%.			X	X
3. Local health department staff conduct outreach efforts to health care providers in their county to provide education and information on lead screening.			X	X
4. The Childhood Lead Poisoning Prevention Program has contracts with 57 local health departments and New York City to provide prevention programs and provide care coordination.	X	X	X	X
5. Additional funding to the Childhood Lead Poisoning			X	X

Prevention Program was used to assist local health departments with targeting high incidence areas.				
6. Wadsworth Center operates a public health lead screening laboratory where blood from children throughout the state is tested for lead levels.			X	X
7. The Center for Environmental Health will take the lead on primary prevention efforts related to environmental lead in housing.			X	X
8. Local health departments nursing and environmental staff met to discuss current research and emerging trends related to lead poisoning prevention in children and pregnant women and primary prevention.			X	X
9. The five existing lead coalitions met in Syracuse in June 2006 to discuss their grant projects and lessons learned.			X	X
10. Environmental assessment and assistance on abatement are available from local health departments and NYSDOH district offices.			X	X

b. Current Activities

- WIC and PCAP continue to stress the need for preventive services for infants, including lead screening.
- A major statewide educational campaign was conducted by NYSDOH in August 2007 in association with major lead-related recalls of children's toys. Statewide mailings were sent to 27,115 pediatric health care providers and 17,857 child care providers.
- Local health department programs actively link lead poisoned children with special health care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned case is automatically given a developmental screening and/or referred to local Early Intervention (EI) program to ensure care coordination
- The Childhood Lead Poisoning Prevention Program was re-funded by the CDC.
- The Department is collaborating with the Office of Children and Family Services (OCFS) to provide child care providers in New York State with education and supporting materials to promote providers' role in lead screening and parent education. The Department is working with OCFS and the State University of New York Training Strategies Group to develop training materials for child care providers using monthly videoconferences.
- Updates and enhancements continue to be made to the electronic, relational lead registry, LeadWeb.

c. Plan for the Coming Year

- Continued development of LeadWeb and release of expanded data.
- Continue with implementation of statewide Lead Elimination Plan.
- Development and dissemination of additional educational materials and clinical tools for health care providers.
- No additional major changes.

State Performance Measure 11: *Percent of High School Students who watched 3 or more hours of TV on an average school day.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				40	38

Annual Indicator	43.6	43.6	41.9	41.9	35.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	34	33	32	31	30

Notes - 2007
Numerator and Denominator data are not available (2007 YRBS survey data)

Notes - 2006
2005 data are being used as a proxy for 2006. Numerator and denominator data are not available (survey data).

Notes - 2005
Data are based on the 2005 YRBS. Numerator and Denominator are not available (survey data).

a. Last Year's Accomplishments

- This is a new measure as of last year. The measure replaces a State Performance Measure on overweight WIC children which became a National Performance Measure. This measure was selected due to the relationship between television watching and overweight in teens.
- The Coordinated School Health Team worked to support the School Health Index Incentive Program. After completing the index schools formulate plans to address their deficiencies. Over $1.3 million was distributed to 364 schools to improve policy and environmental changes to improve healthy eating and increase physical activity.
- The goals of the obesity prevention program formerly known as Activ8Kids! are to get kids to consume 5 fruits and vegetables each day, to participate in at least one hour of physical activity each day and to limit screen time to 2 or less hours daily. This is done by incorporating these messages into a variety of activities and programs.
- "Steps to a Healthier New York" is in four counties in NYS (Broome, Chautauqua, Jefferson and Rockland). This is an approach to working with entire communities. Each site must have a school coordinator to pull the community activities into the school.
- Eight regional Type 2 Diabetes Prevention in Children projects successfully implemented interventions to increase opportunities for physical activity and healthier food choices for children in home, school and community environments.
- The School Nutrition and Physical Activity Tool kit was distributed to 3,400 schools in New York State. The electronic version is on the public website.
- Twenty-four (24) school districts are participating in the Healthy Schools Leadership Institute, which promotes and supports good nutrition and physical activity in schools.
- FitWIC trainers (about 20 NYSDOH staff, mainly from the WIC Program) conducted and coordinated FitWIC sessions at the annual WIC Association conferences. The WIC Program assesses screen time and provides participant-centered nutrition counseling/education on healthy lifestyles. FitWIC, a physical activity initiative, has completed training WIC local agency staff at all 100 agencies from January 2005 to June 2007 on how to interact with WIC families to focus on good health and physical activity rather than weight. FitWIC teaches simple age-appropriate movements, and incorporates cultural games and activities that support a life-long habit of staying active. The WIC Program also has a Special Projects Grant funded by USDA to support FitWIC research.
- Pre- and post-surveys were completed for the BMI-for-age project.
- New York has laws mandating physical education in schools and that all student complete a mandated, semester-long course in health.
- Since 2004, the Healthy Heart Program has funded local organizations that have worked with 1,275 schools (reaching 443,727 students) statewide to improve policy and environmental supports for nutrition and physical activity. Physical activity improvements include: increasing active time during physical education, increasing the number of children walking or bicycling to

school, increasing opportunities for physical activity (e.g. installing climbing walls, providing snow shoes, etc), improving or maintaining recess times, and prohibiting the use of physical activity as a punishment. Nutrition policies adopted include: increasing the availability of low-fat milk, increasing the number of healthful options sold in school stores and vending machines, prohibiting the use of unhealthy foods as rewards, and prohibiting the sale of unhealthy foods as fund raising activities. MCH Block Grant funds support approximately 50% of this activity.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Coordinated School Health Team worked to support School Health Index Incentive Program. After completing the index, schools formulate plans to address their deficiencies. Over 300 schools participated.			X	X
2. The Coordinated School Health Team worked to support School Health Index Incentive Program. After completing the index, schools formulate plans to address their deficiencies. Over 300 schools participated.			X	X
3. “Steps to a Healthier New York” is in four counties in NYS. This is an approach to working with entire communities. Each site must have a school coordinator to pull the community activities into the school.			X	X
4. The School Nutrition and Physical Activity Tool kit is on the public website.			X	X
5. Twenty-four school districts participated in the Healthy Schools Leadership Institute, which promotes and supports good nutrition and physical activity in schools.			X	X
6. The WIC Program continues to promote FitWIC through 1:1 counseling sessions and facilitated group sessions with exercise/activities. The 20 FitWIC trainers conducted and coordinated FitWIC sessions at the 2005 and 2006 annual WIC conferences.			X	X
7. BMI data collected during the oral health surveillance are analyzed and being disseminated.			X	X
8. New York has laws mandating physical education in schools and that all student complete a mandated, semester-long course in health.			X	X
9. 250 schools made healthy changes affecting over 75,000 students.			X	X
10.				

b. Current Activities

- This measure will be tracked through the Youth Risk Behavior Survey.
- See National Performance Measure 16.
- Currently, the Department has a number of initiatives that address improving physical activity, including the Coordinated School Health Team/School Health Index Incentive Program, Activ8Kids!; "Steps to a Healthier New York" in four counties; Eight Type 2 Diabetes Prevention in Children projects; the School Nutrition and Physical Activity Toolkit; the Healthy Schools Leadership Institute, which promotes and supports good nutrition and physical activity in schools; and FitWIC, a physical activity initiative in WIC.
- The WIC Program also has a Special Projects Grant funded by USDA to support Fit WIC research and continue activities/exercises at WIC local agencies.
- New York continues to mandate physical education in schools and that all student

complete a mandated, semester-long course in health.

- This year, legislation passed that will require physicians to enter BMI results on the school physical forms required for school entry and periodically throughout the child's school years.

c. Plan for the Coming Year

Legislation is pending to improve school nutritional programs.

State Performance Measure 12: *Percent of Women that felt down, depressed or hopeless always or often after their baby was born.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				11.5	11.4
Annual Indicator		10.4	9.9	8.3	8.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8	8	7.5	7.5	7

Notes - 2007

2006 data are being used as a proxy for 2007. Data are from the NYS PRAMS survey which includes women residing in NYS outside of NYC.

Notes - 2006

Data are from the NYS PRAMS survey which includes women residing in NYS outside of NYC.

Notes - 2005

Data are from the NYS PRAMS survey which includes women residing in areas in NYS outside of NYC.

a. Last Year's Accomplishments

This was a new performance measure as of the FFY 2007 application. This measure replaces a State Performance Measure on smoking during pregnancy, which became a National Performance Measure. This measure has been tracked using PRAMS and was selected based on the implications of maternal depression on health of the mother, parenting styles, family functioning and child outcome.

- The Department's 24 Community Health Worker Programs have policies and procedures for conducting perinatal depression screening and making referrals for further evaluation if needed. Community Health Workers educate pregnant and postpartum clients about perinatal depression including signs and symptoms and the availability of help and local resources. All pregnant and postpartum clients are screened for depression using a standardized screening tool such as the Edinburgh Postnatal Depression Scale. CHWP coordinators closely supervise all cases where there is a positive screen. In 2007 the CHWP served 2,749 women, of which 83 pregnant and 54 postpartum women were referred for further evaluation and treatment.
- NYSDOH worked closely with the NYS Office of Mental Health and Postpartum Support International of New York to develop a successful media campaign on perinatal depression. The campaign included television and radio spots, bus sides and bus/subway posters, and provider fact sheets. This was originally piloted in one region and later materials were made available statewide.

• Materials were made available to all Comprehensive Prenatal-Perinatal Services Networks, Healthy Starts, Prenatal Care Assistance Programs, MOMS and other providers.
• Media Kits, complete with fill-in-the-blanks press releases, were made available to all Networks and local health departments.
• Materials were posted on the NYSDOH website. These materials include patient education information, a provider fact sheet and materials for public education campaigns. Providers are able to add local contact information for services in their area.
• The Growing Up Healthy Hotline was prepared to take calls.
• Comprehensive Prenatal-Perinatal Services Networks implement a variety of strategies designed to improve pregnancy outcomes including improving access to health care services and promoting positive behaviors. CPPSN activities in 2007 around prenatal/postpartum depression included:
- The Bronx Health Link trained 36 providers on postpartum mood disorder screening, including identifying risk factors and making referrals.
- Caribbean Women's Health Association (CWHA) in Brooklyn produced a program on access television on perinatal depression.
- CWHA in collaboration with Maimonides and SUNY Downstate hospitals conducted a regional perinatal forum on perinatal depression, screening and referrals.
- The Nassau County Perinatal Services Network's conference entitled "It's Not Just the Blues: A New Look at Perinatal Mood Disorders," was attended by 205 providers. Presentations included identifying perinatal mood disorder, Beck Postpartum Depression Screening Scale, and models of treatment interventions.
- The Suffolk Perinatal Coalition's (SPC) annual conference focused on Perinatal Mood Disorders. A total of 190 providers and community members attended. Presentations included research-based model of primary intervention, local models of support, and advocacy. Mary Jo Codey, former first lady of New Jersey spoke on dealing with maternal depression.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. This measure is tracked using PRAMS data.			X	X
2. NYSDOH worked closely with the NYS Office of Mental Health and Postpartum Support International of New York to develop a successful media campaign on post-partum depression. The campaign included TV and radio spots, bus sides and subway signs.	X	X	X	X
3. Materials were made available to all Comprehensive Prenatal/Perinatal Services Networks, Healthy Starts, Prenatal Care Assistance Programs/MOMS and other providers. Media Kits, complete with fill-in-the-blanks press releases, were made available.			X	X
4. The Bureau of Women's Health received multiple requests for materials from other states.			X	X
5. Materials were prepared for posting on the website. Local contact information for services was made available.			X	X
6. In 2006, the Growing Up Healthy Hotline took over 360 calls on perinatal depression and directed callers to resources in their area.		X		X
7. Comprehensive Prenatal/Perinatal Networks conducted professional education sessions, including co-hosting conferences, grand rounds and in-services.		X	X	X
8. Networks conducted consumer education, developed support groups for women with perinatal depression, and developed			X	X

materials that promote awareness and services for perinatal depression.				
9. NYSDOH and the Office of Mental Health released consumer education materials and medication guidelines.			X	X
10. The CHW program screened all pregnant and postpartum women for depression, and referred 83 pregnant and 54 postpartum women for further evaluation and treatment.		X		X

b. Current Activities

- Materials are available on the NYSDOH public website.
- The Growing Up Healthy Hotline continues to take calls on perinatal depression and refer callers to appropriate services.
- Community Health Workers continue to screen clients for signs and symptoms of depression, both prenatally and in the postpartum period.
- Comprehensive Prenatal/Perinatal Networks continue to promote awareness of and provide information on dealing with perinatal depression.
- NYSDOH staff continue to work with the Office of Mental Health and various stakeholders to plan future activities.

c. Plan for the Coming Year

Continue to implement current recommendations.

E. Health Status Indicators

New York updates its full needs assessment, including Health Status Indicators, annually. Annual updates are needed to track trends in resident health status and to ssist in program planning, monitoring and evaluation. Please see Section II Needs Assessment for trend graphs and health status indicators for various Maternal and Child Health Population Groups. Please refer to forms 20 and 21 for annual reporting of Health Status Indicators.

/2009/ In summary, Health Status Indicators in NYS have, for the most part, remained fairly stable during the past two years for which final data were available. Low birth weight has remained stable from 2005, at 8.3 percent, but is higher than the 2003 rate of 7.9 percent. The rate of singleton low birth weight births has shown an identical trend, but at roughly two percentage points lower (currently at 6.4 percent.) Very low birth weight births have also been very stable, at roughly 1.5 percent for all births, and 1.2 percent for singleton births, for 4 of the past 5 years.

Rates of deaths to children 14 and younger from unintentional injuries have shown some fluctuations over the past five years. The rate per 100,000 children is down from 2004, but up from 2003, when it was 3.4/100,000. The rate for the past three years has been 3.7/100,000. Likewise, the rate of deaths among children age 14 and younger due to motor vehicle injuries has shown similar fluctuations, peaking in 2004 at 2.2 deaths per 100,000 children, and at the lowest rate in the past five years in 2003 (0.7/100,000), but stable over the past three years (1.3 motor vehicle-related deaths per 100,000 children age 14 and under). For older children (15-24) there has been an increase over the past 5 years, from 12.3 to 14.2 deaths per 100,000 children 15-25, with very little change since 2005. Nonfatal injuries to children 14 and younger, on the other hand, have decreased over the past five years, from 267.5 in 2003 to 243.4 per 100,000 children 14 and younger, with a peak in 2004 at 284.1. Over the past five years, non-fatal injuries to children 14 and

younger and 15-24 were at their lowest point in 2003, and rose sharply in 2004, declining in 2005, and rising again in 2006-2007.

Chlamydia rates in women 15-19 and 20-44 have shown somewhat different patterns. While rates among younger women have been fairly flat, ranging from 23.3 per 1,000 women 15-19 in 2003 to a high of 25.7 in 2004, with stable rates of 25.6 in subsequent years, the rates for women 20-24 increased steadily from 2003 through 2006 (the most recent year of final data), from 6.6 to 11.4 per 1,000 women 20-44. //2009//

/2008/A major focus for NYSDOH is on health disparities and the achievement of health equity. Numerous indicators are broken down by race and ethnicity in an effort to determine if certain groups are not benefiting equally from current interventions. //2008//

F. Other Program Activities

- /2008/Vital Records processed over 125,000 birth records; 95,000 death records; 80,000 marriage records; 65,000 divorces; 15,000 research records; and 22,000 genealogy-related requests.//2008//
- Wadsworth Center provided public health laboratory facilities to the residents of New York State including, but not limited to, laboratories for testing water purity, for identifying lead levels and strains of microorganism (anthrax, botulism, rabies, E. coli, and other bacterial and viral organisms), for diagnosis of sexually transmitted diseases, for review of cytologic specimens, including pap smear review, for an anatomic pathology analysis, for cytogenetic identification of prenatal and clinical abnormalities, and for identification of reproductive and metabolic disorders. Wadsworth Center operates state-of-the-art clinical laboratory and environmental laboratory evaluation programs to ensure that laboratories offering tests to NYS residents meet appropriate quality requirements and can pass proficiency tests. Wadsworth Center performs basic scientific research to ensure that technologic advances and scientific knowledge have application in public health. Wadsworth Center maintains appropriate laboratory capacity in the event of an epidemic or terrorist attack.
- The Genetic Centers provided educational opportunities to medical students (approximately 200 programs), practicing health professionals (about 300 programs), people with a diagnosed genetic condition (about 80) and the general public (about 175). The Genetic Program works closely with March of Dimes to produce educational materials for populations with an interest in genetics or with a genetic condition.
- /2008/The Division of Family Health initiated discussion with the Office of Emergency Preparedness to ensure that the needs of the maternal and child health population would be adequately addressed in times of emergency. As a result, a Maternal and Child Health Preparedness Workgroup was formed, for which there are several subcommittees. Title V staff have been involved in the formulation of Continuity of Operations Plans, pediatric and obstetrical formulary discussions, and emergency planning for pandemic influenza. Presently, staff are working on guidelines for non-pediatric and non-obstetrical hospitals that may be asked to care for pediatric or obstetric patients in an emergency.//2008//
- ***/2009/ Title V staff have been involved in community engagement meetings for pandemic flu planning. Four regional meetings will be held throughout the state, and families of CSHCN have been invited to attend these regional meetings. Title V staff will facilitate at one regional meeting. //2009//***
- The New York State Preventive Medicine Residency Program provided academic and/or practicum training to seven physicians, including three with strong interests in MCH. Residents contributed to a wide variety of initiatives in maternal and child projects.
- The Fluoride Supplementation Program provided educational training on early childhood oral health issues to day care centers, Head Start centers and professional educators. Supplemental fluoride is distributed across the state to school and Head Start centers in non-fluoridated area. Children participate with the consent of their parents.
- The Dental Public Health Residency Program graduated three residents from its

statewide program. The Program continued its accreditation status and proceeds to collaborate with the other four dental residency programs in New York State.

- The Rape Crisis Program continued to implement the DOH Hospital-Based Sexual Assault Forensic Examiner Program. ***/2009/ NYSDOH developed standards for approving Sexual Assault Forensic Examiner (SAFE) hospital programs, approving programs that train individual SAFE examiners, and certifying individual SAFE examiners. //2009//***
- In 2006, 15 Migrant and Seasonal Farmworker Health Program contractors provided primary healthcare to more than 8,000 adults and 5,000 children, ages 18 and under. About 2,500 children and adults received dental care. The program completed over 13,800 screenings for blood pressure, vision, hearing, blood lead, HIV/AIDS, STDs and tuberculosis. They provided more than 9,900 educational encounters, over 16,400 translation encounters, 6,000 transportation encounters and 19,000 home visits.
- Regional Perinatal Forums are operational in all regions of the state. The Perinatal Networks have become co-leaders with Regional Perinatal Centers in the development and implementation of the Forums in their regional areas. The purpose of the Forums is to engage medical providers, community based organizations and other key stakeholders in identifying perinatal health problems and developing solutions, from a public health perspective, in a regional action plan. This process and these activities impact many of the measures identified above.
- The provision of early intervention services to eligible infants and toddlers took into account the specific needs of the family and the types of services required that would enhance the child's development. Services are based on the results of multidisciplinary evaluation.
- /2008/The Department convened a Child Health Improvement Partnership focused on standardizing tools for increased identification of children with developmental problems. //2008
- /2008/The basic functionality of recording and registering births was completed and the Statewide Perinatal Data System (SPDS) Core module was implemented. During 2006, programming was complete to generate statewide reporting and to provide data access to individual hospitals and de-identified reports to regional perinatal centers. //2008//
- /2008/NYSDOH continues to work with NYCDOHMH Vital Records to adapt the Statewide Perinatal Data System (SPDS) for New York City births. New York City is recognized by the Federal government as a separate vital records registration district and therefore maintains its own birth certificate system. It is anticipated that New York City will begin implementing a new vital records system in January 2008 that will collect data in a manner that is compatible with the requirements of the SPDS.
- /2008/The NYS Osteoporosis Prevention Program Regional Center at the Hospital for Special Surgery is conducting a multi-year "SNEAKER" project. The SNEAKER curriculum incorporates the food pyramid guidelines. Workshops were conducted for 16- to 21-year-old girls. The Long Island regional resource center has continued to build on TWEEDS, an interactive website for osteoporosis education (www.tweedsnet.com/bone). Professional education on osteoporosis was provide throughout NYS to communicate current, evidence-based information about prevention, diagnosis and treatment. Universal recommendations for bone healthy behaviors are a cornerstone of this educational effort. //2008//
- /2008/In 2006, a total of 21,102 referrals were made by the Community Health Worker Program for health care services, transportation, education and support services. 89% of referrals were completed.//2008// ***/2009/ In 2007, a total of 18,942 referrals were made by the CHWP for health care services, transportation, education and support services. 87% of referrals were completed.//2009//***
- /2008/All municipalities conducted Early Intervention outreach activities to ensure that eligible infants and toddlers in whom a developmental delay was suspected received timely evaluation. Approximately 4.29% of the State's birth through age two population and 1.11% of the State's population under age one received Early Intervention Services during the program year.//2008//
- /2008/The Bureau of Occupational Health staff have developed a Heavy Metals Registry Annual Report 2000-2005, which has been posted on the NYSDOH website.//2008//

G. Technical Assistance

Title V staff /continue to //2008//recommend a second "large states" technical assistance meeting to discuss issues of mutual concern.

/2008/Last //2008//year, New York /2008/requested//2008// TA in the areas of genetics services and adolescent health. /2008/ This year, we are asking for Technical Assistance to implement our plans for fluoride varnish. We are requesting TA from a large state that has implemented early childhood programs in pediatricians offices and public health settings where very young children are served.//2008//

V. Budget Narrative

A. Expenditures

Completion of Budget Forms: Please refer to budget columns on Forms 2, 3, 4, and 5 for a summary of state, local, federal and program income as it contributes to the MCH Partnership.

Principles for Allocation: Also, please refer to the Principles for Allocation of Maternal and Child Health Services Block Grant Funds in the Needs Assessment.

Historical Note: Due to ongoing allocation reviews and expenditure disbursement analyses, reallocations have resulted with efforts made to reduce the unobligated balance. Until the FFY 2005 application, carryover was noted in the "Unobligated Balance" column. In reality, all funds were obligated, though not all spent at the time of submission. NYSDOH was given guidance from HRSA that these funded should not be shown as unobligated. Therefore, starting with the FFY 2006 application, budgeted and expended amounts are shown on Form 3 within Line 1 only and are not displayed as unobligated balance. The total Federal allocation is committed to program services and will no longer be viewed as unobligated.

Concerted efforts are made to reduce the carryover balance by addressing areas of need as indicated in emerging public health issues for mothers and children. Program areas receiving increased fund allocations include: nutrition and physical activities in schools, oral health and pediatric overweight initiatives. ***/2009/ As of 2007, there is no carryover balance on the MCH block grant funds. All funds were expended.//2009//***

/2008/Each year, program managers are required to fill out a survey on an internal web portal, from which service information is pulled for calculation of final expenditures by MCH population group and by level of the MCH pyramid.//2008// ***/2009/ Effective for this application, the data set previously used to collect both programmatic and fiscal data from program and administrative staff was no longer available. A new method of collecting these data was developed, which differed substantially from the previous data system. The information collected, though, remained remarkably stable despite the significant difference in collection methods.//2009//***

B. Budget

Maintenance of Effort: New York meets and exceeds the maintenance of effort requirements of Section 505 (a) (4). The New York State Department of Health plans continued Title V funding for the following efforts in FFY 2009:

- The Adolescent Health Initiative, including ACT for Youth and Youth Risk Behavior Surveillance;
- An Adolescent Health Coordinator;
- American Indian Health Program Community Health Workers;
- Asthma Coalitions;
- Children with Special Health Care Needs Program, including the Physically Handicapped Children's Program Diagnostic and Evaluation Program;
- Columbia Collaborative Projects;
- Community-Based Adolescent Pregnancy Prevention;
- Congenital Malformations Registry;
- Family Planning;
- The Genetics Program and Newborn Metabolic Screening;
- SUNY School of Public Health MCH Graduate Assistantship Program;
- Health Communications;
- ***/2009/ NYS Youth Development Team Coordinator; /2009/***

- ***Immunization activities;***
- ***Infant and Child Mortality Review;***
- ***Infertility Demonstration Project;***
- ***Injury Prevention;***
- ***The Lactation Institute;***
- ***Lead Poisoning Prevention;***
- ***Migrant and Seasonal Farmworker Health;***
- ***Newborn Hearing and Metabolic Screening;***
- ***Innovative Oral Health Initiatives;***
- ***Osteoporosis Prevention;***
- ***Parent and Consumer Focus Groups;***
- ***Public Health Information/Community Assessment infrastructure;***
- ***The Statewide Perinatal Data System;***
- ***Preventive Dentistry Initiatives and the Dental Residency Program, including an expanded dental sealant program and a Task Force on Oral Health in Pregnancy;***
- ***School-Based Health Centers and School Health Infrastructure;***
- ***STD Screening and Education;***
- ***Universal Newborn Hearing Screening;***
- ***Vital Records; and***
- ***Women and Disabilities.***

The Monroe Consolidated Child and Family Health Grant will continue in FFY 2009. Under this initiative, seven grants are given to the county with an integrated work plan.

Methodology: Effort is made to match funding to the level of unmet need, and to address the four layers of the MCH pyramid and the three target populations. Because funded programs often take more than one structural approach to targeted needs and populations, program appropriations are proportioned out to reflect percentage of effort in infrastructure-building, population-based services, enabling services and direct health care services. Program appropriations also take into account the "30-30-10" requirements of Title V.

New York State uses a fair method to allocate Title V funds among individuals and areas identified as having unmet needs for maternal and child health services. The State uses its MCH funds for the purposes outlined in Title V, Section 505 of the Social Security Act. The MCHSBG Advisory Council assists the Department in determining program priorities and has been instrumental in seeking public input into the application process. The Council developed in 1984 a document entitled "Principles and Guidelines for the Use of Block Grant Funds," which was updated and affirmed each year. New York is using an Oracle-based system of gathering program information which more finely delineates sources of funds for the programs for only the second year. /2009/ As previously stated, the Oracle-based system has been replaced in the current year with a more streamlined fiscal information gathering system.// 2009//

The methodology used to identify State expenditures for MCH-related programs has not changed:

- ***Appropriate cost centers, representing specific areas of activity related to MCH, are identified.***
- ***Data for the appropriate fiscal periods are obtained from the Office of the State Comptroller (OSC).***
- ***Data for selected cost centers are extracted on a quarterly basis.***
- ***Quarterly data is compiled from relevant cost centers to reflect expenditures made during the federal fiscal year.***
- ***All expenditure data represent payments made on a cash (vs. accrual) basis.***
- ***Transactions associated with specific grants are identified and tracked through***

appropriation, segregation, encumbrance and reporting processes to permit proper and complete recording of the utilization of available funds.

- ***Identifying codes are assigned to record these transactions by object of expense within each cost center.***

Any amount payable to the State under this title from allotments for this fiscal year which remain unobligated at the end of that year are carried forward and obligated in the following fiscal year. The Department and the Office of the State Comptroller (OSC) maintain budget documentation for Block Grant funding and expenditures consistent with Section 505(a) and Section 506(a)(1) for the purpose of maintaining an audit trail. The grant expenditures are recorded through standard OSC documents.

Reporting requirements and procedures for each particular grant are instituted to comply with conditions specified within each notice of grant award.

The state share in MCH services is considerable, more than meeting the requirements for state match. State appropriations dedicated to MCH include:

- ***/2009/HIV-related appropriations: Children, Adolescents and Families Affected by AIDS/HIV, High Risk women and children, HIV prevention and health care services to high risk adolescents and young people, Comprehensive Health and Supportive Services for Women and Children, Maternal and Child HIV Services, HIV Prevention Programs for Adolescents, Permanency Planning and Supportive Services for Families Affected by HIV, Grants to CBOs for Provision of HIV Education and Prevention Services for Youth at Risk in a School Setting, HIV Counseling and Testing Services in Family Planning Program Projects, and ACT for Youth -- Assets Coming Together for Youth.//2009//***
- Child Care;
- Early Intervention;
- Family Planning;
- Genetic Screening and Human Genetics;
- Health Care Reform Act Allocations;
- Immunization, Vaccine Distribution and State Aid for Immunization;
- Lead Control and Prevention, Lead Poisoning Prevention Local Assistance and Lead Interim Housing;
- Physically Handicapped Children's Treatment Program/Children with Special Health Care Needs Program;
- ***/2009/ Migrant and Seasonal Farmworker Health Program;***
- ***Community Health Worker***
- ***Comprehensive Prenatal-Perinatal Services Networks***
- ***Perinatal Regionalization***
- ***Maternal mortality initiative (Safe Motherhood)***
- ***Support for higher level infertility services //2009//***
- School-Based Health Centers;
- State Aid to Local Health Departments;
- SIDS and Infant Death; and
- Tobacco Settlement Dollars.

Federal sources of MCHSBG dollars other than the block grant included:

- Abstinence Education ***/2009/ (through 9/30/07 only) //2009//***;
- Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure; Oral Health Surveillance, Oral Health Systems ***/2009/ , HIV/CAPC;//2009//***);
- CISS grants;
- Early Intervention, Part C;
- Family Planning;

- ***/2009/ Preventive Health and Health Services Block Grant; //2009//***
- Rape Crisis;
- STD/fertility;
- SPRANS Grants;
- ***/2009/ HRSA -- Ryan White HIV/AIDS Treatment Modernization Act of 2006;//2009//***
- SSDI Funds;
- TANF Funds;
- Early Childhood Comprehensive Systems planning grant.

A regional analysis of Title V external contracts shows that about 65% of funds are contracted for the metropolitan New York City area, where most of the State's population is located; about 16% goes to the Western New York area, our second most populous region; about 11 % goes to Central New York; and about 8% goes to the Northeastern and Capital District areas of the state. These breakdowns are fairly consistent with the proportion of New York's population residing in each of these areas.

/2008/The State more than meets "30-30-10 Requirements" for 30% allocation to primary and preventive care to children ($13,846,454 or 33.26%), for 30% for children with special health care needs ($13,905,147 or 33.40%) and under 10% for administration ($2.585,600 or 6.211%).//2008//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.